Supporting the Mental Health *of Youth in Juvenile Court*

Resource Guide *and* Bench Cards

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1. Introduction

Up to 80 percent of youth in foster care have significant mental health issues as compared to approximately 22 percent of youth in the general population.[1] Up to 70 percent of youth who touch the juvenile justice system have a diagnosable mental health issue.[2] These issues are the result of both biological and environmental factors including exposure to trauma, violence, extreme stress, and separation from important persons. Yet many will remain undiagnosed or untreated. In California, less than half of the foster youth who are eligible for mental health services will receive them.[3]

The juvenile court judicial officer plays a unique leadership and oversight role in the courts, not only helping to ensure agencies and individuals are meeting the needs of youth, but also providing active leadership in determining the needs of youth and obtaining and developing resources and services to meet those needs.[4]

This guide is intended to support judicial officers in California to make informed decisions and orders for youth[5] in the child welfare and juvenile justice systems, including those with mental health needs. While this guide is not inclusive of every mental health topic, it should provide a road map of funding, services, and approaches that better support such youth.

Discussion of mental health topics can be triggering and fraught with preconceptions. We may lack the language to best describe the variety of experiences held by the diverse populations that struggle with mental illness. In this guide, we use the terms *mental health* and *mental illness*, while recognizing the variety of experience that may not be fully captured in such terms.

2. Mental Health and the Juvenile Courts: Overarching Values

The judicial officer can play an important role in addressing the mental health needs of youth in court by supporting the identification of youth with unmet needs, ensuring the completion of quality assessments, confirming a strong treatment plan is implemented, and monitoring the provision of care. There are some important themes for the court to keep at the forefront through each stage of that process.

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[1] Polihronakis, *Mental Health Care Issues of Children and Youth in Foster Care* (National Resource Center for Family-Centered Practice and Permanency Planning, Apr. 2008), p. 3.

[2] Developmental Services Group, Inc., *Intersection between Mental Health and the Juvenile Justice System* (Office of Juvenile Justice and Delinquency Prevention, July 2017), p. 1.

[3] Cal. Dept. of Health Care Services, *Performance Outcomes System Children in Foster Care Statewide Report* (Aug. 9, 2017), *www.dhcs.ca.gov/services/MH/Documents/FMORB/20170831_FC_STATE_ADA.pdf*.

[4] Cal. Stds. Jud. Admin., std. 5.40(e) & (h).

[5] The words *children, youth,* and *minor* are used interchangeably throughout this guide to refer to young people we are seeking to support.

Supporting Good Mental Health Is Not Just About Addressing Symptoms

"Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives."[6] A youth's ability to engage effectively in services will depend on their feeling safe and supported. Many decisions made in court that may not, on the surface, appear to impact a youth's mental health may, in fact, prevent them from creating or maintaining the safe environment that is critical to healing. For a youth to be able to participate fully in any recommended service, it is essential that they have a sense of stability in placement, visitation schedules, education, and other building blocks for a secure environment. When we focus on adding positive supports and activities to a youth's life instead of taking away problematic behavior that may still serve a survival purpose, we make long-term healing possible.

Trauma and the Importance of Trauma-Informed Practices

Every child entering a juvenile court has experienced some level of trauma. Many have experienced complex trauma: repeated traumatic events in early life, often involving a caregiver, that can impact child development and a child's relationship to the world.[7] Not surprisingly, many youths will react and respond to this trauma. Systems working with traumatized youth can improve responses to trauma in two ways. The first is to recognize the prevalence of trauma, the signs and symptoms of trauma, and the need for support. The second is to incorporate trauma-informed practices, both in the provision of mental health services and in court itself.

Recognizing trauma begins with understanding the different types of trauma and its most common manifestations. Exposure to early childhood trauma can restrict brain growth and is associated with increased acting-out behavior and school failure later in life.[8] Adverse childhood experiences, such as witnessing domestic violence or having a parent who struggles with mental illness, have a significant impact on health and criminal justice contact later in life.[9] Without an understanding of trauma, problematic behavior may be misinterpreted. Further, training on trauma provides empathy and a common language for providers and systems to unify in their approach to working with youth.

The courtroom environment may escalate youth who have experienced trauma. Some trauma-informed practices for the courtroom to minimize such escalation include the following:

- Engage with the youth and ask questions to build appropriate rapport.
- Utilize a strengths-based approach to identifying goals and providing feedback.
- Provide a clear explanation of what will happen during the proceeding to provide predictability for the youth.

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[6] van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (Penguin Books 2014) p. 79.

[7] National Child Traumatic Stress Network, "Complex Trauma" (undated), *www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma*.

[8] Buffington et al., *Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency* (2010), *www.ncjfcj.org/sites/default/files/trauma%20bulletin_1.pdf*.

[9] Centers for Disease Control and Prevention, "Adverse Childhood Experiences (ACEs)" (undated), *www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html*.

- Ensure the courtroom environment is free of unnecessary triggers, such as police officers jingling keys behind the youth or anyone seeking personal mental health information in open court.[10]

Not all children who have experienced trauma will receive a mental health diagnosis. The diagnosis of posttraumatic stress disorder addresses only a subset of trauma responses and that may not be present for most youth who have experienced trauma. Incorporating trauma-informed practices ensures that even youth who have not been (or may never be) formally diagnosed will still have their experience recognized.

Youth may experience trauma beyond the personal level as well. Systemic, historical, or insidious trauma impacts the lives of youth on a daily basis in the forms of discrimination, institutionalized racism,[11] oppression, poverty,[12] and microaggressions.[13] This type of chronic stress is less likely to end up in a court report or identified within an evaluation but has a significant impact on the lives of youth nonetheless. While the solution to such large-scale problems cannot be addressed in an individual court case, the acknowledgment of such powerful forces at work in a youth's life can help them to feel seen and help the judicial officer understand the challenges the youth faces.

The National Child Traumatic Stress Network (NCTSN) has published a resource entitled *The NCTSN Bench Card for the Trauma-Informed Judge*,[14] with suggestions on how to bring trauma-informed practice into the juvenile court. Judicial officers are encouraged to inquire about the child's trauma history to provide context for what may otherwise be considered troublesome behavior, and to then incorporate that knowledge into other decisions about further evaluation, collaboration, and other services. Some of these recommendations are incorporated into this resource guide and the accompanying bench card series.

Culture and the Importance of Culturally Responsive Services

Culture can influence problem identification, utilization of assistance, and the efficacy of services provided. A child's background will shape how the child understands and responds to behavior. Culture can influence what is considered "normal" behavior, including how a child learns to manage difficult situations and how the child learns "appropriate" ways to express emotions. Some youth may have to learn different ways of being to function in different communities and cultures, such as school and their home environment. Culture also can influence how a family responds to different types of mental health services, including whether they perceive any stigma to receiving formal support from outside providers.

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[10] Substance Abuse Mental Health Services Administration, U.S. Dept. of Health and Human Services, *Essential Components of Trauma-Informed Judicial Practice* (2013), www.nasmhpd.org/sites/default/files/DRAFT_Essential_Components_of_Trauma_Informed_Judicial_Practice.pdf.

[11] Panko, "Racism Harms Children's Health, Survey Finds" (May 5, 2017) *Smithsonian,* www.smithsonianmag.com/science-nature/racism-harms-childrens-health-180963167/.

[12] American Psychological Association, "Effects of Poverty, Hunger, and Homelessness on Children and Youth" (undated), www.apa.org/pi/families/poverty.

[13] Runyowa, "Microagressions Matter" (Sept. 18, 2015) *The Atlantic*, www.theatlantic.com/politics/archive/2015/09/microaggressions-matter/406090/.

[14] Available at www.nctsn.org/sites/default/files/resources//nctsn_bench_cards_for_the_trauma_informed_judge.pdf.

Culture also influences assessment. Some assessment tools used in behavioral health have not been validated for use with different cultures or populations.[15] Some rely on child, parent, and community member reports on a child's behavior and whether that individual interprets the child's behavior as within normal range. Their answers will depend on their cultural context.

Culture, therefore, should play a role in treatment. In developing a treatment plan, the American Academy of Child and Adolescent Psychiatry (AACAP) states that "[w]hen a mental health professional is needed, it is important to find someone who understands that culture can affect [the] child's behavior, development, diagnosis, and treatment. This is called culturally informed or culturally competent care."[16] If mental health professionals who share or are familiar with a child's cultural background are not available, AACAP recommends mental health professionals consider doing the following to be able to provide more culturally competent care:

- With permission, working together with cultural, community, or religious organizations
- Supporting parents and caregivers in using behavioral management skills that are in line with their beliefs and values
- Including family members who are "non-blood relatives" in the evaluation and treatment when requested by family or the child
- Recognizing the types of therapy and medications that work best in youth from specific diverse groups
- Appreciating and recognizing cultural biases and how they can interfere with treatment"[17]

For both assessment and treatment, AACAP recommends that mental health professionals gather cultural information, including:

- Cultural values and religious beliefs
- Languages spoken at home and school and different family members' preferred language
- Traditional medicines or treatments
- Parenting practices and discipline methods
- The role of family and community in the child's life
- What is expected of youth at different ages in the child's culture
- How and when feelings are shown in the family and community
- The family's immigration or transition experience, including losses and trauma
- Factors that make it difficult for the family to obtain mental health care, including transportation, finances, and cultural beliefs
- The child's cultural strengths[18]

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[15] Desai et al., *Primer for Juvenile Court Judges: A Trauma-Informed Approach to Judicial Decision-Making for Newcomer Immigrant Youth in Juvenile Justice Proceedings* (NCTSN, Feb. 2019), p. 23.

[16] AACAP, "Diversity and Culture in Child Mental Health Care" (Jan. 2019) *Facts for Families*, *www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Diversity_and_Culture_in_Child_Mental_Health_Care-118.aspx*.

[17] *Ibid.*

[18] *Ibid.*

A clinician with cultural sensitivity and knowledge will be able to provide better assessment and care than one who does not understand the child's cultural context.

Disproportionality

Disparate treatment of youth from different cultures both in the community and in assessment and treatment leads to disproportionality: the over- or underrepresentation of some groups at risk for certain mental health diagnoses. These differences may be due to environmental factors that concentrate higher stress and trauma in certain populations, but also can be due to lack of early intervention services. For example, many studies have identified racial and ethnic disparities in diagnoses and access to appropriate care.[19] Multiple studies also have demonstrated that LGBTQ youth experience more depression, anxiety, and attention deficit disorders.[20] Disproportionality can skew in both directions. There is a risk of under- and overdiagnosis for certain populations, as well as a risk of over- or undertreatment (such as overmedication or failing to provide adequate care after a diagnosis).

Centering Youth in the Process

Youth engagement is essential for successful mental health treatment outcomes because it improves youth buy-in, trust, and empowerment. Even when a minor's consent for health services is not legally necessary (see Section 8, Consent, below), engaging the youth and seeking the minor's *assent* at each stage can be helpful for therapeutic purposes. For mental health care to be fruitful, a patient must be a willing participant in treatment. If a youth is reluctant to participate, then the minor's parent, service provider, probation officer, social worker, attorney, or others, as appropriate, should work to identify and attempt to alleviate the minor's concerns or find an alternative treatment that is based on the youth's input.

Mental health services should be individually tailored to the specific youth's and family's needs. This requires youth engagement. Case plans, treatment plans, assessments, and services are not one-size-fits-all. The youth's voice should be evident throughout evaluation, teaming, and implementation of services.

Additional Resources

- *NCTSN Bench Card for Court-Ordered Trauma-Informed Mental Health Evaluation of Child*
- Supreme Court of Ohio, *Juvenile Court Trauma-Informed Practices*
- National Council of Juvenile and Family Court Judges, *Addressing Bias in Delinquency and Child Welfare Systems*

[19] Alegria et al., "Racial and Ethnic Disparities in Pediatric Mental Health" (Oct. 2010) 19(4) *Child Adolescent Psychiatry Clinics N. Am.* 759.

[20] Luk et al., "Sexual Orientation and Depressive Symptoms in Adolescents" (May 2018) *Pediatrics.* See Becerra-Culqui et al., "Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers" (May 2018) *Pediatrics.*

3. Case Plans and Court Reports: Gathering Information, Identifying Unmet Needs, and Possible Orders

At every hearing, the court must consider and determine whether the youth's mental health needs, including any need for special education and related services, are being met. The court should determine whether there is enough information to make such findings, inquire of the youth and other parties to obtain necessary information, or make orders to ensure that gaps in treatment are addressed.[21]

Case Plan and Court Report Requirements

At every hearing (beginning with disposition in dependency and when the youth enters foster care in wardship proceedings), the agency must submit a case plan with a description of assessments and services provided to the youth and an evaluation of the appropriateness and effectiveness of services.[22]

Required contents of a case plan—assessments, collaboration, youth involvement:

- The case plan should be based on input from the Child and Family Team (CFT). At the CFT, the team should discuss worries and strengths of the child and family. If the youth requires mental health services, this should be noted within the youth's case plan.[23]
- Placing agencies must ensure a youth receives a Child and Adolescent Needs and Strengths (CANS) assessment (a mental health and substance use screening tool) prior to completion of a case plan and that the CFT has the results. The CFT should use the results to inform decisions in multiple areas, including unmet mental health and education needs and placement planning.[24]
- If the CANS results suggest there may be a need for specialty mental health services, the placing agency must refer the youth to the county Mental Health Plan. This referral must be documented in the Child Welfare Services Case Management System.[25]
- Starting at age 14, the case plan must include a written description of the programs and services that will help the youth, consistent with the youth's best interests, to prepare for the transition from foster care to successful adulthood.[26]
- At age 16, the case plan must document whether or not there is a pending application for Supplemental Security Income (SSI) or Special Immigrant Juvenile Status for youth.[27]
- The youth must be involved in the case plan development at an age- and developmentally appropriate level.[28]

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[21] Cal. Rules of Court, rules 5.649(d), 5.651(b)(2).

[22] Welf. & Inst. Code, §§ 706.5, 706.6, 16501.1(e) & (g)(14); Cal. Rules of Court, rules 5.690(c), 5.785(c).

[23] Welf. & Inst. Code, § 16501.1(g); Cal. Dept. of Social Services, *Manual of Policies and Procedures* § 31-206.

[24] Cal. Dept. of Social Services, All County Letter No. 18-09, Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No. 18-007.

[25] *Ibid.*

[26] Welf. & Inst. Code, § 16501.1(g)(16).

[27] Welf. & Inst. Code, § 16501.1(g)(16)(A)(ii).

[28] Welf. & Inst. Code, § 16501.1(g)(1), (13).

- Youth must review and sign the case plan beginning at age 12.[29] The plan must be developed in consultation with the youth starting at age 14.[30]

Court report:

- The agency must attach the youth's health and education passport to every court report. The passport must include relevant mental health history, known conditions, and medications.[31]
- In addition, to the extent available, the agency must include in the court report the youth's mental health and developmental needs and whether the youth has physical, mental, or learning-related disabilities or other characteristics indicating a need for developmental services or special education and related services as provided by state or federal law.[32]
- The court report must state if the youth may be eligible for or already receiving services.[33]
- The agency report must include recommendations and case plan goals to meet the youth's mental health needs and requested orders to direct the appropriate persons to obtain assessments, evaluations, or services for the youth.[34]

Findings and Orders

- At every hearing, the court must find that the case plan meets the requirements of Welfare and Institutions Code section 16501.1. If it does not, the court must order the agency to comply.[35]
- At every dispositional and detention hearing, and at all subsequent hearings that may affect a youth's receipt of education or developmental services, the court must consider and determine whether the youth's mental health needs, including any need for special education and related services, are being met.[36]
- Findings and orders must address what services, assessments, or evaluations the youth may need.[37]
- If the court determines a child is in need of mental health assessments, evaluations, or services, the court "must direct an appropriate person to take necessary steps to request those assessments, evaluations, or services."[38]
- At any time after a petition has been filed, the court may, following notice and a hearing, join in the proceedings any agency that the court determines has failed to meet a legal obligation to provide services to the youth. If or when other responsible agencies are actually joined in the litigation, the court may request agency representatives meet before the hearing to

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[29] *Ibid.*

[30] Welf. & Inst. Code, § 16501.1(g)(17).

[31] Welf. & Inst. Code, § 16010.

[32] Cal. Rules of Court, rule 5.651(c)(2), (5).

[33] Cal. Rules of Court, rule 5.651(c)(6), (7) & (9).

[34] Cal. Rules of Court, rule 5.651(c)(14) & (15).

[35] Cal. Rules of Court, rules 5.690(c)(2)(B), 5.708(e)(2).

[36] Cal. Rules of Court, rule 5.651(b)(2).

[37] *Ibid.*

[38] Cal. Rules of Court, rule 5.649(d).

coordinate the provision of services. The court has no authority to order services unless it has been determined through the administrative process of the agency, that the youth is eligible for those services.[39]

- If the court finds that the youth needs a Regional Center or special education screening, the court may direct the rights holder to take appropriate steps.[40]
- The court may make an order limiting a parent's right to make health and educational decisions for the youth, and must clearly and specifically set forth those limitations.[41] The court must identify the educational rights holder at each hearing.[42]
- At disposition, the court may require production of other relevant evidence on its own motion.[43]

Identifying Youth With Possible Unmet Needs

Even if a youth has been evaluated previously, a new mental health evaluation may be appropriate when:

- A child is demonstrating behaviors or expressing feelings that appear to be linked to a mental health condition, such as problems concentrating, appearing confused, avoiding eye contact, lethargy, or defiance or aggression.
- Problematic behaviors that were attributed to a particular placement, a series of placement changes, or some other external factor have not diminished since the presumed source of the problem has gone.
- A child is not responding to medication or therapy.
- Physical conditions have been ruled out as a possible cause of the youth's behavior.

This list is not exclusive. More information and examples can be found in the following resources: Georgia Courts, *Judicial Guide to Mental Illness in the Courtroom*, and the National Alliance on Mental Illness, *Know the Warning Signs*.

Assessing the Quality and Sufficiency of Information

Not all evaluations are created equal. The court should consider the quality of the evaluations that come before it when deciding how much weight to give the recommendations in the assessment.

When assessing the quality of evaluations, consider the following:

- What background information did the evaluator have available?
- Did the evaluator take culture and language into account in interpreting the results of the assessments?
- Has the child recently experienced a traumatic life event? This may impact the efficacy of evaluations and treatment.

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[39] Welf. & Inst. Code, §§ 362, 727; Cal. Rules of Court, rule 5.575.

[40] Cal. Rules of Court, rule 5.651(b)(2)(C).

[41] Welf. & Inst. Code, §§ 361(a), 362, 726, 727; Cal. Rules of Court, rule 5.695(b).

[42] Cal. Rules of Court, rule 5.649.

[43] Cal. Rules of Court, rule 5.690(b).

- What type of evaluation was performed? Was the evaluation performed by a qualified professional?
- Did the evaluator speak with all of the relevant individuals? If not, were there gaps in the evaluation as a result?
- Is the child's level of willingness to participate evident in the evaluation?
- Did the evaluator include all of the suggested elements listed under "Psychological evaluation" on page 11?
- What is the agency's plan to follow up on the recommendations of the evaluation?

Ordering New or Additional Evaluations

The findings and orders of the court must address whether the youth needs assessments or evaluations and, if needed, who must take the necessary steps for the child to receive them.[44] If any agency is failing to meet a legal obligation to a youth, the court may join the agency in the proceeding by court motion.[45] If the court finds that a youth needs a Regional Center or special education screening, the court may direct the rights holder to take appropriate steps.[46]

When ordering a placing agency or rights holder to have an evaluation performed, consider the following:

- Has the child received necessary medical, dental, vision, and hearing screenings? Untreated physical health conditions can be misdiagnosed as mental health conditions; for example, a child who is unable to see or hear materials at school may be more likely to act out in class.
- Are there reasons to refer the child for a Regional Center evaluation? Developmental disabilities may impact diagnosis and treatment of co-occurring mental health conditions.
- Are there reasons to refer the youth for an evaluation in school? Indicators of a need for a school assessment include that the youth is behind grade level, having disciplinary issues, or has been diagnosed in another setting.
- Has the child had a psychological evaluation in the past year? Evaluations can be taxing and should not be repeated unnecessarily.
- Are the child, the family, and the child's team in agreement with the evaluation?
- Will the child have to miss school to be evaluated?
- Will the child have to be transported a long distance for the evaluation? Will this impact other life activities, visitation, or education?
- Which providers or parties should have access to the evaluation once it is completed?

Types of Evaluations

Evaluations serve different purposes. They can be conducted to determine eligibility for services, to establish a baseline or diagnosis for treatment, or to determine a youth's capacity to participate in the legal process. The motivation for the evaluation will determine the type of professional who conducts it, as well as the nature of the recommendations. While all evaluations typically provide

[44] Cal. Rules of Court, rule 5.561(b)(2), (e) & (f).

[45] Welf. & Inst. Code, §§ 362(b), 727(b); Cal. Rules of Court, rule 5.575; *Notice of Hearing on Joinder—Juvenile* (form JV-540).

[46] Cal. Rules of Court, rule 5.651(b)(2)(C).

recommendations for services, diagnoses, and conclusions, these conclusions should be interpreted for the setting or service for which the evaluation was targeted.

While evaluation is an essential step in diagnosing mental health conditions and identifying a plan for treatment, not all youth who have experienced trauma or who require treatment will meet criteria for formal diagnosis. Ongoing consideration of supportive services is necessary for all youth, regardless of needs identified in a formal evaluation.

Child and Adolescent Needs and Strengths (CANS) assessment. All youth and nonminor dependents who enter the child welfare system or who enter foster care through the probation system will receive a CANS assessment. This tool assesses the youth for general well-being and mental health needs. A CANS assessment is also utilized to track outcomes and to support coordination of services and collaborative decision-making. The CANS assessment should be completed prior to the development of a case plan and should inform the Child and Family Team, a process required for all youth placed out of home. If the screening indicates that the youth may be eligible for Specialty Mental Health Services, they should be referred to the local Mental Health Plan. Youth receiving Specialty Mental Health Services should be reassessed using the CANS assessment every six months.[47]

Competency evaluation. As required by Welfare and Institutions Code section 709, a competency evaluation is required when the court has a doubt that a minor who is the subject of a proceeding under Welfare and Institutions Code section 601 or 602 is legally competent. While the requirements of the evaluation and evaluator are established in Welfare and Institutions Code section 709, the timeline for the evaluation is established by local protocol.

Neuropsychological evaluation. A neuropsychological assessment evaluates the child's thinking abilities and can be utilized to rule out traumatic brain injury or other cognitive conditions. The evaluations are a series of skills tests performed by the youth to understand their cognitive strengths and weaknesses. The results are used to help diagnose conditions and plan treatment.[48] Such assessments can be used to diagnose or rule out conditions such as ADHD, intellectual disabilities, epilepsy, and traumatic brain injury. A neuropsychologist who is trained to evaluate brain function and test abilities such as attention, memory, language, and spatial skills performs the evaluation. If a neuropsychological assessment is medically necessary, it is covered under Medi-Cal. A neuropsychological evaluation may be medically necessary when there is a need to diagnose "cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands."[49] (For more information, see Section 6, Treatment and Placement, Services for Youth Placed in the Community, below.) School districts may be required to pay for a

[47] Cal. Dept. of Social Services, All County Letter No. 18-09 (Jan. 25, 2018), Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool Within a Child and Family Team.

[48] UCSF Benioff Children's Hospital San Francisco, "What is a Neuropsychological Assessment?" (undated) www.ucsfbenioffchildrens.org/education/what_is_a_neuropsychological_assessment/.

[49] Medi-Cal Update, Psychological Services (Jan. 2018), Bulletin 508, section 4, *https://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/psy201801.asp*.

neuropsychological evaluation if it is related to a child's disability for which they have or may be eligible for an Individualized Education Plan.[50]

Psychoeducational evaluation. Psychoeducational evaluations are used to understand the mental processes underlying educational performance and are often used to identify learning disabilities. They are the first step qualifying for an Individualized Education Plan (IEP), or in the alternative, a 504 plan in public school (i.e., a plan for how the school must provide accommodations that will ensure the student's success and access to the academic environment).[51] A psychoeducational evaluation must be completed for the initial IEP and every three years thereafter in order to maintain eligibility. Youth with 504 plans may receive less formalized assessments. The portion of the psychoeducational examinations used to determine eligibility for an IEP under the category of emotional disturbance tend to rely heavily on rating scales given to parents/caregivers, teachers, and, when age appropriate, the student. Once requested of a school, this evaluation must be completed within a statutorily set timeline, typically 60 days from when the parent or educational rights holder requests the assessment in writing. (For more information on school services and eligibility, see Section 6, Treatment and Placement, Services Through the School, below.)

Psychological evaluation. Psychological evaluations are used to determine the history and current functioning (typically including a *Diagnostic and Statistical Manual of Mental Disorders* diagnosis) of an individual's psychological condition. It is especially important for the evaluator to have the subject's childhood history, because that information is necessary to make certain diagnoses. Evaluations are a combination of testing, interviewing, and observations. The evaluations should be conducted as a series of interviews with the child, their family, and other members of the child's network. An evaluation conducted in a single interview is far less useful, in part because an evaluator may not observe the subject's problematic behaviors during a limited time frame. The evaluator should be qualified to conduct evaluation and testing. Psychological evaluations typically conclude with findings, diagnoses, and recommendations for treatment, utilizing a medical model of treatment.

Recommended elements for evaluation include the following:

- Presenting problem
- Relevant health conditions and psychosocial factors
- Mental health history
- Medical history
- Medications
- Substance abuse history
- Client strengths
- Risks
- Mental status examination

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[50] 34 C.F.R. § 300.34(a) & (c)(5); see Disability Rights California, *Special Education Rights and Responsibilities*, ch. 2, p. 7, www.disabilityrightsca.org/system/files?file=file-attachments/504001Ch02.pdf.

[51] A student is eligible for an IEP of modified instruction because of specific qualifying disabilities. A 504 plan provides some accommodations so that a student is able to access the curriculum. An IEP requires specific procedural safeguards and documentation of measurable progress, but a 504 plan does not.

- Complete diagnosis
- Additional clarifying information as needed[52]

Regional Center developmental assessment. Evaluations at a local Regional Center assess for developmental delays and can be used to qualify a child for Regional Center support services.

For babies 0–35 months, eligibility for Regional Center services is based on the percentage of functioning in the following areas: cognition, communication, social or emotional, adaptive, and physical. A high-risk condition or multiple risk factors for developmental disability can also make a child eligible.[53] The Regional Center has 45 days from the date of parent contact or agency/physician referral to complete the initial evaluation and assessment for eligibility, and to develop the Individualized Family Service Plan for those determined eligible. Regional Center–eligible children should automatically be assessed for special education services and possibly ongoing Regional Center support at least three months before their third birthday.

For youth age three years and above, eligibility for Regional Center services is based on a diagnosis of autism, cerebral palsy, intellectual disability, or epilepsy, and the degree to which the disability impacts the youth's functioning, communication, and independence. Initial intake must be performed within 15 business days following the request for assistance. This initial intake determines whether a formal assessment is called for. Thereafter, the Regional Center has 120 calendar days to determine eligibility. However, if the delay would result in a risk to the person's health and safety, the Regional Center will determine eligibility within 60 days.[54] For those who qualify for an assessment, Regional Center assessments are funded through the Department of Developmental Services. (For more on Regional Center funding and eligibility, see Section 6, Treatment and Placement, Other Programs and Funding Sources, below.)

4. Common Mental Health Diagnoses and Treatments

Diagnoses

The most common *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnoses[55] for youth in foster care fall into six broad categories:

- Mood disorders
- Anxiety disorders
- Thought disorders
- Attention-deficit and disruptive behavior disorders

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[52] Cal. Dept. of Health Care Services, Mental Health Services Division, Program Oversight and Compliance, *Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services Fiscal Year 2015–2016* (Sept. 9, 2015), p. 97, *www.dhcs.ca.gov/formsandpubs/Documents/15-042_Enc1_RvwProtocol.pdf*.

[53] Cal. Dept. of Developmental Services, "What Is Early Start?" (undated), *www.dds.ca.gov/EarlyStart/WhatsES.cfm*.

[54] Autism Comprehensive Educational Services (ACES), "Regional Center System in California" (undated), https://acesaba.com/resources/californiaregionalcentersystem/.

[55] Solchany, "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges" (Oct. 2011) *Practice & Policy Brief* (ABA Center on Children and the Law), p. 5, *www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf*.

- Elimination disorders
- Other disorders

For descriptions and examples of specific diagnoses in these categories, see Appendix III of this guide.[56] In addition to these, other common categories for diagnoses include learning disorders, pervasive developmental disorders such as autism, feeding/eating disorders, adjustment disorders, and dissociative disorders.[57]

Within these six broad categories, some of the common diagnoses seen in juvenile court include:

- Attention deficit hyperactivity disorder (ADHD)
- Posttraumatic stress disorder (PTSD)
- Anxiety
- Depression
- Bipolar disorder
- Disruptive mood deregulation disorder
- Oppositional defiance disorder
- Other mood disorder

Treatments

Depending on the diagnosis, the most commonly recommended treatments often include a combination of one or more of the following strategies:

- Behavioral therapy
- Child-parent psychotherapy
- Cognitive behavioral therapy (CBT)
- Dialectical behavioral therapy (DBT)
- Play therapy
- Psychopharmacology (medication)

These are defined and described further in Appendix IV of this guide.[58]

Psychopharmacology is typically used to alleviate or lessen the symptoms of a mental health disorder and may be recommended in combination with other treatments. The most common medications prescribed to youth in care fall into four categories:

- Mood stabilizers
- Antipsychotics
- Anti-anxiety medications
- Stimulants

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[56] *Ibid.*

[57] *Id.* at p. 4.

[58] For additional evidence-based practices, see the California Evidence-Based Clearinghouse for Child Welfare: Information and Resources for Child Welfare Professionals, *www.cebc4cw.org*.

Appendix V of this guide provides descriptions and examples of common medications in these and other categories, including their subgroups, common side effects and the symptoms they target.[59]

While medication preferences change and new medications become available, some of the medications often prescribed to youth in care include the following, listed by category:

- Alpha agonists
- Antidepressants/selective serotonin reuptake inhibitors (SSRIs)
- Antipsychotics
- Mood stabilizers
- Antihypertensives
- Sedatives

California is taking steps to improve psychotropic medication prescription and use with youth under court jurisdiction. The court plays an important role in this process. The Foster Care Quality Improvement Project of the Department of Health Care Services and the Department of Social Services created *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care*, a best-practices guide for evaluating psychotropic medication requests that is recommended for judicial officers and other stakeholders.[60]

5. Evaluating Behavioral Health Services and Plans

The courts provide an important oversight role. Many stakeholders in the community emphasize that there is a range in quality of care and that services should not be one-size-fits-all but instead tailored to the specific youth. In this section, we will provide basic information on how to find expertise in the community and suggest questions to ask to understand if a thoughtful plan is being presented.

Evaluating the Quality of a Recommended Treatment Plan

When reviewing a treatment plan, consider the following:

- Were you able to obtain an accurate medical, behavioral, and psychological history from parents and past providers?
- What modes of treatment have been recommended?
- What evidence supports this recommendation?
- Does the child agree with this plan?
- Who will provide these services? Is there a provider in place?
- Is funding clear? Who must consent for this care and is that consent in place?
- Who will monitor treatment?[61]

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[59] Solchany, *supra*, at p. 5.

[60] Cal. Dept. of Social Services & Cal. Dept. of Health Care Services, Foster Care Quality Improvement Project, *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* (2018), www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Guidelines_18.pdf.

[61] Solchany, *supra*, at pp. 27–29.

In addition, consider the following circumstances that may have impacted formation of the treatment plan:

- Has the child recently moved, or is the child moving placements? How will this change the provision of services? Is there a plan to ensure there are no gaps in care or access to services?
- Is the provider team able to coordinate effectively and share appropriate information in a timely way?

Evaluating Services Being Provided

Questions to evaluate school-based services:

- Has the youth changed schools recently or will the youth be changing schools? If so, a 30-day transition plan is required at the new school for students with IEPs.
- Does the child have access to appropriate services and accommodations on campus to help them regulate emotionally (i.e., scheduled breaks, access to trusted adults/school psychologist, use of sensory tools, etc.)?
- If the student has mental health–related behavioral challenges, has the school done the right mental health assessments to accurately determine the causes and triggers for the student's behaviors and identify the appropriate responses?

Questions to evaluate mental health services:

- How often does the child see the provider? Breaks in treatment prevent rapport building, which is essential to the safety required in therapy for a client to open up.
- How long has the child seen the provider? Building trust with a mental health provider takes time and is essential to treatment progress. There are not usually instant results.
- Is the provider experienced? A more experienced clinician will be likely to be more effective and maintain a longer relationship with the client as opposed to an intern who is new to the job and will likely be leaving the agency at the end of the internship.
- Is the provider using a particular theory or strategy? The goal of therapy will vary depending on the type of therapy the clinician practices or whether any theory is utilized at all.
- Where do they meet? If therapeutic services take place in a public place or in a treatment program where they cannot speak privately, it may be more challenging for the young person to share openly.
- Is the provider culturally competent?

Psychotropic Medication Review

When reviewing a psychotropic medication request, in addition to the questions above in evaluating a treatment plan,[62] consider the following:

- Is the prescriber a child psychiatrist? How long ago did he or she complete the mandatory *Physician's Statement—Attachment* (form JV-220(A))? How long has he or she worked with the child?

[62] *Ibid.*

- Was the child's and the child's caregiver's input included in the *Application for Psychotropic Medication* (form JV-220) packet filed with the court?
- Is the child also receiving nonpharmacological services as treatment for the diagnosis?
- Are there recent placement changes, hospitalizations, or other life events that could have impacted the symptoms of the child's mental health condition?
- Is the medication appropriately prescribed to treat the diagnosis that the child has? Is the dosage within the FDA parameters for the child's age?
- Have necessary labs been completed or ordered?
- Is there a follow-up appointment with a psychiatrist to review progress on the medication?

The Foster Care Quality Improvement Project provides further detail on red flags and prescribing parameters.[63]

6. Treatment and Placement

Least Restrictive Environment

A prevailing principle in the foster care and probation systems is that youth should be placed in the most home-like setting and receive services tailored to address their individual needs. This principle should guide case planning and is at the core of the legal standards the court must follow. Indeed, in both systems, youth are to be placed in the least restrictive setting possible.[64] Preventing restrictive placements is essential to improving outcomes for foster youth. Youth in foster care who are placed in group homes (now called Short-Term Residential Treatment Programs) have worse outcomes in the areas of permanency, education, and contacts with probation.[65] In cases where a youth must be placed in a treatment program, the case plan must include a plan for discharge and transition as soon as that placement decision is made.[66]

Tailored, Coordinated Care in a Home Setting

Often, providing appropriate and sufficient services and supports can ameliorate the need for more restrictive placement.[67] This may mean obtaining and coordinating services from a variety of providers and agencies to meet the individual needs of the youth. These services may be provided through the county Mental Health Plan, the school district, a congregate placement, and/or another provider such as the Regional Center; frequently, services overlap and require coordination.

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[63] Cal. Dept. of Social Services & Cal. Dept. of Health Care Services, Foster Care Quality Improvement Project, *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* (2018), www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Guidelines_18.pdf.

[64] Welf. & Inst. Code, §§ 16501.1(d), 727.1(a).

[65] Cal. Dept. of Social Services, *The Promise of the Continuum of Care Reform (CCR),* www.cdss.ca.gov/Portals/9/CCR/CCRInfographic.pdf?ver=2017-10-18-161318-400.

[66] Welf. & Inst. Code, §§ 706.6(d)(3), 16501.1(d).

[67] See Youth Law Center, *Advocating for the Most Connected Placement: A Guide to Reducing the Use of Group Care* (May 15, 2019), https://ylc.org/wp-content/uploads/2019/05/Connected-Placements-Toolkit.pdf.

The CANS assessment and other evaluations may suggest referral to one of these agencies if necessary. Placing agencies have an affirmative duty to make that referral. The Child and Family Team play an important role coordinating and supporting collaboration.

Services for Youth Placed in the Community

Services Through Medi-Cal

Eligibility

Medi-Cal offers free or low-cost health coverage for California residents who meet eligibility requirements. All youth in foster care are eligible for full-scope Medi-Cal, including youth who are placed in a legal guardianship established by a dependency court or youth adopted through the foster care system. Former foster youth are also covered under Medi-Cal until age 26 if they were in foster care placement on their 18th birthday. Youth with full-scope Medi-Cal (in contrast to partial-scope Medi-Cal) are covered for a wide variety of medical services including primary medical, mental health, vision, and dental care.

Youth not placed in foster care may still be eligible for Medi-Cal based on their family income bracket, whether they receive SSI, or any of the other 80-plus ways that one can be eligible for Medi-Cal.

Undocumented California residents under the age of 18 are eligible for full-scope Medi-Cal. While Deferred Action for Childhood Arrivals (DACA) eligible adults up to the age of 21 may also be eligible for full-scope Medi-Cal, all other undocumented adults are not eligible to receive full-scope Medi-Cal after they reach adulthood.

Individuals under age 21 on Medi-Cal will have their Medi-Cal suspended while they are in custody in a "public institution" such as a juvenile hall, camp, or ranch.[68] Juvenile halls are provided and maintained by the county board of supervisors, with expenses tracked by the probation department.[69]

Managed Care Organization (MCO) and Medi-Cal

Medi-Cal managed care organizations are responsible for providing lower intensity mental health services, such as psychotherapy, to youth on Medi-Cal. If the youth's case plan suggests possible need for such services, the placing agency has an affirmative duty to identify the youth and make a referral.[70] The division of labor between MCOs and Mental Health Plans turns on the severity of the mental health needs and varies somewhat from county to county. Most youth will be assigned to one or the other, but may be treated by both.

County Mental Health Plan (MHP) and Medi-Cal Specialty Mental Health Services (SMHS)

Medi-Cal Specialty Mental Health Services are available through the county Mental Health Plan for youth who meet medical necessity criteria under Medi-Cal. Eligible youth receive services necessary

[68] Welf. & Inst. Code, § 14011.10; see Cal. Dept. of Health Care Services, All County Letter No. 10-06 (Mar. 23, 2010), Suspension of Medi-Cal Benefits for Incarcerated Juveniles, *www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-06.pdf*.

[69] Welf. & Inst. Code, §§ 850, 855.

[70] See Cal. Rules of Court, rule 5.651(c).

to treat a medically necessary condition. These may include therapy, crisis counseling and stabilization, special day programs, therapeutic behavioral services, and *Katie A.* services.

A placing agency must refer a youth to the MHP for evaluation if a CANS assessment suggests a possible need for SMHS. The MHP must accept the results of a CANS assessment provided by the agency but may consider whether any updates are appropriate. The MHP must make an individual determination regarding eligibility for SMHS. If deemed eligible, services are provided and funded by the MHP, in collaboration with the agency.

As part of the eligibility evaluation, the youth must be diagnosed, the MHP must determine that the condition would not be responsive to physical health treatment, and the treatment provided has to be focused on and expected to diminish the impairment caused by the diagnosis.[71] "Medical necessity" criteria are defined slightly differently depending on the types of service being provided and are described in the California Code of Regulations:

- Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services (Cal. Code. Regs., tit. 9, § 1820.205).
- Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age (Cal. Code. Regs., tit. 9, § 1830.210).

Services Available Through Medi-Cal SMHS. If a child meets medical necessity criteria under Medi-Cal, the child may receive any service required to treat a medically necessary condition that has been covered in any state by Medicaid, even if the service is not a part of the California plan.[72] If a medically necessary service is not available in the MHP's network, the MHP may be required to individually contract for the necessary care.

These services are typically provided to the child and the child's family in the community, at home, or in a home-like setting if the child meets medical necessity criteria under Medi-Cal for services. Services may include, but are not limited to:

- Intensive Care Coordination
- Intensive Home Based Services
- Therapeutic Behavioral Service (community-based support that "wraps around" the youth)
- Psychotropic medication evaluation
- Individual, group, and family therapy
- Crisis counseling and stabilization
- Special day programs

Early Periodic Screening Diagnosis and Treatment (EPSDT) and the *Katie A.* Settlement Agreement

EPSDT is a federal entitlement that requires states and counties to provide comprehensive and preventative health care services to low-income youth under 21 who are enrolled in Medicaid (the California version of the Medicaid program is Medi-Cal). EPSDT provides for "[s]uch other necessary health care, diagnostic services, treatment, and other measures … to correct or ameliorate

[71] Cal. Code Regs., tit. 9, § 1830.210.

[72] Center for Medicare and Medicaid Services, *EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), p. 23, www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[73]

Katie A. v. Bonta (*Katie A.*)[74] challenged the sufficiency of services being provided to EPSDT-eligible youth in foster care. The settlement agreement adopts and endorses a new array of services for these youth. One of the primary goals of the *Katie A.* settlement agreement is to provide an individualized and coordinated array of services to meet a youth's mental health needs while allowing the youth to stay in the most home-like placement.[75] *Katie A.* services are intensive Specialty Mental Health Services intended to meet a youth's needs and stabilize placement, and may include Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care.

Katie A. services utilize the Core Practice Model (CPM) to guide provision of mental health services. The CPM emphasizes principles of youth engagement; inclusion of a Child and Family Team to inform service delivery; home-based services (when possible); services that are culturally relevant, tailored, and individualized; and a blend of formal and informal services.[76]

Youth eligible for SMHS and who are under age 21 may qualify for a range of services, including the following:

- Day treatment.
- Therapeutic behavioral care.
- Intensive Home Based Services (IHBS): Services designed to support the youth's functioning in the home and community. Such services should be individualized and targeted to increase the youth's functioning.
- Intensive Care Coordination (ICC): An intensive form of targeted case management, appropriate for youth served by multiple systems. The Child and Family Team must guide provision of ICC. The Child and Family Team facilitator often comes from the county Mental Health Plan when the youth is receiving ICC.
- Therapeutic Foster Care (TFC): Short-term, intensive, highly coordinated, trauma-informed and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC may be appropriate for youth already served by ICC and IHBS but whose needs are not being met and who are at risk of losing their placement.

The Mental Health Plan must make an individual determination regarding eligibility for SMHS and medical necessity for *Katie A.* services such as ICC, IHBS, and TFC.

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[73] 42 U.S.C. § 1396d(r)(5).

[74] (C.D. Cal. 2006) 433 F.Supp.2d 1065; (9th Cir. 2007) 481 F.3d 1150.

[75] Cal. Dept. of Social Services, *Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TF) Services for Medi-Cal Beneficiaries* (3d ed. Jan. 2018), p. 7, *www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf*.

[76] Cal. Dept. of Health Care Services & Cal. Dept. of Social Services, *Pathways to Mental Health Services: Core Practice Model Guide* (undated), pp. 8–11, www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf.

Medi-Cal Substance Use Disorder (SUD) Services

Eligible youth with Medi-Cal can receive substance abuse treatment and early intervention services. These services include outpatient and school-based programs, as well as residential treatment and transitional services upon discharge from such programs. Services vary between counties depending on local needs and priorities.[77]

Private Insurance and Medi-Cal

If a family has private medical insurance and the child is remaining in the home, the child may still be eligible for and receive Medi-Cal services, but the family's private insurance will be billed first. There are other unique circumstances under which Medi-Cal and private insurance are used together, such as when an individual has a high-cost medical condition and is at risk of losing private insurance (Medi-Cal Health Insurance Premium Payment program).

Medi-Cal: Eligibility and Services in Different Placement Types

Home-like environments. A child is entitled to receive community-based services when placed in the following settings:

- Therapeutic Foster Care (TFC).
- Intensive Services Foster Care (ISFC): Foster placement for youth who require intensive medical or mental health support as well as a higher level of supervision. A resource parent or non-relative extended family member can become an ISFC provider or a foster family agency may provide ISFC.[78]
- Resource family: A caregiver who has completed the current state licensing process. A relative or family friend usually is given first priority for placement.
- Foster family agency (FFA): A private agency that supports resource families, TFC families, and ISFC families who had no prior connection to the youth. FFAs are required to provide, or contract to provide, the following Specialty Mental Health Services:
    - Transition Services (support services for initial entry and for placement changes)
    - Education, Physical, Behavioral, Mental Health, and Extracurricular Supports
    - Transition to Adulthood services
    - Permanency Support Services
    - Indian Child Services

The services must be culturally relevant and trauma-informed.[79]

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[77] Cal. Dept. of Health Care Services, "Youth Substance Use Disorder Services" (undated), www.dhcs.ca.gov/individuals/Pages/youthSUDservices.aspx.

[78] Welf. & Inst. Code, § 18360.10 et seq.

[79] Welf. & Inst. Code, § 11463 et seq.; Cal. Dept. of Social Services, *Core Services Matrix* (Oct. 12, 2017), *www.cdss.ca.gov/Portals/9/CCR/STRTP/STRTP%20Core%20Services%20Matrix%20-%2010.12.17.pdf?ver=2017-10-12-105650-673*.

Congregate care. A child is entitled to receive community-based services in the following settings:

- Short-Term Residential Treatment Program (STRTP): A residential facility licensed through the State of California to provide treatment, 24-hour care, and supervision for foster youth. STRTPs must provide all of the services listed above required of FFAs. STRTPs are not locked facilities. To ensure successful treatment, STRTPs are required upon referral or intake to complete the following tasks (among others):
    - Upon referral, an individualized assessment of the youth's strengths to determine whether the youth would benefit from the program and the extent to which the youth's needs are represented by the existing client population.[80]
    - Upon admission, youth must receive an initial crisis management assessment with input from someone the youth requests to be present. The assessment includes an evaluation of escalation triggers, de-escalation techniques, an advance directive regarding the use of seclusion or restraints, relevant medical history that could place a youth at risk during seclusion or restraints, and trauma history.[81]
    - Upon admission, a needs and services plan that is consistent with the Child and Family Team and case plan. The needs and services plan should include a plan for reunification and/or permanency and should be updated every 30 days.[82]
    - Upon admission, additional support should be planned for a youth with a runaway history.[83]
    - STRTPS have a legal obligation to create a crisis management assessment that includes techniques for de-escalation.[84]
- Regional Center group home: A facility licensed to provide care and support to individuals eligible for Regional Center services. Disputes may occur over whether the social services agency or the Regional Center should pay for housing a client supported by both agencies.

Out-of-county placement. Foster youth may not be able to stay at a foster home or STRTP within their county of residence. Youth receiving mental health services through Medi-Cal SMHS who are placed out of county are subject to presumptive transfer.

If the youth receives SMHS, in most cases, responsibility for providing those services presumptively transfers to the Mental Health Plan in the new county, and the Mental Health Plan in the new county must accept responsibility for provision of and payment for services. However, the placing agency, youth, person responsible for the mental health decisions of the youth, and interested parties who owe a legal duty to the youth may request waiver of presumptive transfer. The placing agency is

[80] Cal. Dept. of Social Services, Short-Term Residential Therapeutic Program, *Interim Licensing Standards* (Jan. 11, 2019), chapter 7.5, art. 6, § 87068.05 (admission determination procedures).

[81] *Id.*, § 87068.1(d).

[82] *Id.*, §§ 87068.2, 87068.22.

[83] *Id.*, § 87095.24(e)(1).

[84] *Id.,* § 87068.1(d).

responsible for determining the appropriateness of a waiver. The person who requested the waiver, or any other party to the case, may request judicial review of the agency decision.[85]

Services Through the School

Least Restrictive Environment in the Education Setting

Similar to the requirement for mental health services to be provided in a home-based environment when possible, any mental health services for which a youth is eligible under either an Individualized Education Plan (IEP) or a 504 plan (under section 504 of the federal Rehabilitation Act of 1973) should be provided in the least restrictive school environment. In a school setting, the least restrictive environment is a general education setting alongside nondisabled peers. The less time a child spends with the general education population, the more restrictive the environment is considered.[86]

Multi-Tiered System of Support (MTSS) for All Students

MTSS is a framework adopted by the California Department of Education that focuses on aligning resources and initiatives within schools and local education agencies to better support all students. MTSS outlines a system of support aligned with behavioral, educational, and social supports for students. Schools and local education agencies may adopt an MTSS approach.[87]

Within the MTSS, more focused interventions may be used, such as Response to Instruction and Intervention (RtI^2) or Positive Behavioral Interventions and Supports (PBIS). RtI^2 is a strategy that focuses on individual students who are struggling academically to proactively unify school resources to support the student. RtI^2 utilizes tiered levels of intervention targeted to address the student's needs. PBIS centers on the behavioral and emotional learning of students, utilizing evidence-based practices to improve outcomes in learning over time.[88]

Eligibility for School-Based Mental Health Services

A public school has 15 days from receipt of a written request for an IEP assessment to present the parent or rights holder with either an assessment plan agreeing to conduct an assessment or a written notice denying the request. Upon consent to the assessment plan, the district has 60 days to complete its assessments and make its determination. If the district denies the request, the parent or rights holder can pursue review of that decision via due process proceedings.[89] The district must provide services if the youth is found eligible.

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[85] Welf. & Inst. Code, § 14717.1; Cal. Rules of Court, rule 5.647; Cal. Dept. of Social Services, All County Letter No. 17-77 (July 14, 2017), Implementation of Presumptive Transfer for Foster Children Placed Out of County, *www.cdss.ca.gov/Portals/9/ACL/2017/17-77.pdf?ver=2017-07-17-110909-783*.

[86] 20 U.S.C. § 1412(a)(5)(A).

[87] Cal. Dept. of Education, "Multi-Tiered System of Supports" (undated), *www.cde.ca.gov/ci/cr/ri/*.

[88] *Ibid.*

[89] Ed. Code, §§ 56043, 56500.3.

Youth in public school systems may qualify for one of the following:

- **504 plan.** Section 504 of the Rehabilitation Act protects individuals with qualifying disabilities from exclusion from, denial of the benefits of, or discrimination by a school.[90] If found eligible for a 504 plan on the basis of a qualifying disability, the school must provide accommodations that will ensure the student's success and access to the academic environment. To be eligible, the student must have a physical or mental impairment that substantially limits a major life activity. This can include an emotional or mental illness.

- **Individualized Education Plan (IEP).** Under the Individuals with Disabilities Education Act (IDEA), an IEP is a program or plan developed to ensure that a child with recognized disability receives specialized instruction and related services sufficient to allow the student to make educational progress.[91] An IEP has more specific assessment requirements, timeline, and documented goals than a 504 plan.

  Emotional disturbance: Many youths who qualify for school-based mental health services do so under the qualification of emotional disturbance. A youth may qualify for an IEP under emotional disturbance if, upon examination by a school psychologist, the child is found to have one or more of the following conditions: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears.

- **Free, appropriate public education (FAPE).** Any student with a qualifying disability under section 504 or under IDEA is entitled to FAPE. Under FAPE, a student is entitled to receive individualized services that meet his or her needs, in a mainstream environment where possible. The student's educational rights holders are entitled to rights of notice, review, and challenge of decisions. The student is entitled to evaluation and placement procedures to ensure appropriateness of services. The U.S. Supreme Court has found that, for students with IEPs, FAPE requires special education and related services reasonably calculated to enable the student to make appropriate progress given the student's circumstance.[92]

Services Available for Qualified Students

Educationally Related Mental Health Services (ERMHS): Youth who qualify for behavioral health services under an IEP or 504 plan are eligible for ERMHS through the school district even if the identified disability in a child's IEP is not "emotional disturbance." They are eligible for services

[90] 29 U.S.C. § 701.

[91] 20 U.S.C. § 1400 et seq.

[92] *Endrew F. v Douglas County School Dist. RE-1* (2017) ___ U.S. ___ [137 S.Ct. 988, 197 L.Ed.2d 335].

they need in order to benefit from the education plan. Services may include individual counseling, family counseling, psychological services, psychotropic medication, and residential treatment.

Special day class: A separate class, usually within a public school setting, that provides intensive services for youth whose needs will not be met in a regular classroom setting.

Nonpublic school: Privately operated, publicly funded schools that specialize in providing educational support to students whose needs cannot be met in a general public education setting

Residential treatment program: A school district may recommend residential treatment for a student with profound needs. The district may be obligated to pay for this treatment, even if the student also is a foster child.

Other Programs and Funding Sources

Regional Center Services

Regional Centers provide or coordinate services and supports for individuals with developmental disabilities. They are nonprofit private corporations that contract with the Department of Developmental Services.[93]

Eligibility. A person is eligible for Regional Center services if assessed to have a substantial disability under Welfare and Institutions Code section 4512 that begins before the person's 18th birthday that is expected to continue indefinitely. Eligibility assessments are performed by individual Regional Centers.[94] Youth may be assessed starting in infancy.

Assessment. The Regional Center assesses the youth to determine whether they meet eligibility requirements for Regional Center services. The assessment takes into consideration the age of the child, developmental delays, risk factors, and functioning, among other factors. For a further description of a Regional Center assessment, see Section 3.

Services. If eligible for services, the Regional Center will assign the youth a service coordinator to develop a plan for services. The following services are available to Regional Center clients: living arrangements, in-home support services, transportation services, respite care, educational support services, day programs, independent living skills programs, and others.

Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI)

A minor with a qualifying disability may be eligible for monthly supplemental income under Social Security. The Social Security Administration considers income and resources as well as the qualifying disability.[95] The disability must be a condition, or combination of conditions, that result in "marked and severe functional limitations" that seriously limit the child's activities. The disability must be disabling for 12 months or expected to result in death. Eligibility may persist past the age of 18 depending on reassessment of the youth's income and resources. To apply for SSDI, the youth or

[93] Cal. Dept. of Developmental Services, "Information About Regional Centers" (undated), *www.dds.ca.gov/RC/*.

[94] Cal. Dept. of Developmental Services, "Who Is Eligible for Services?" (undated), www.dds.ca.gov/General/Eligibility.cfm.

[95] Social Security Administration, *Benefits For Children With Disabilities* (2019), *www.ssa.gov/pubs/EN-05-10026.pdf*.

the youth's supportive adult sends information about the qualifying condition and the youth's medical information to the local Social Security office along with identification documents.[96]

The agency in custody of a youth in foster care must screen the youth for SSI eligibility at some point between ages 16.5 and 17.5. If the youth screens as likely to be eligible, the agency must submit an SSI or SSDI application on the youth's behalf.[97]

Mental Health Services Act (MHSA)

The Mental Health Services Act[98] was passed as California Proposition 63 in 2004. This robust funding stream supports local and statewide initiatives and services to address mental health needs.[99]

Full Service Partnership (FSP)

FSP funds are a significant portion of the Community Services and Support (CSS) funding through MHSA. FSP and CSS were designed to promote more profound changes in the delivery of mental health services to adults with serious mental illness or youth with serious emotional disturbance. FSPs utilize a "whatever it takes" strategy to support youth with the most significant mental health needs, including outreach and engagement, a personal services coordinator, outpatient mental health services, and clinical support. FSPs vary from county to county. For more information on county programs, see the California Department of Mental Health's *Full Service Partnership Tool Kit.*[100]

Victims of Crime

The California Victims Compensation Board provides funding for youth who have been a victim of crime. Mental health services can be covered if the treatment is related to having been a victim of crime. Minors may also receive up to $5,000 reimbursement for mental health services received to treat emotional injury caused by witnessing a violent crime. Reimbursement rates vary.[101]

Special Considerations for Nonminor Dependents

The majority of Specialty Mental Health Services provided for youth under age 18 are also available for nonminor dependents with full-scope Medi-Cal. However, eligibility for foster care and placement options shifts at age 18.

Medi-Cal eligibility. Foster youth receiving Medi-Cal at age 18 are eligible for full-scope Medi-Cal for Former Foster Youth, regardless of income and resources, until age 26 and will be automatically enrolled by county health upon reaching the age of 18. If not in Medi-Cal at age 18, they may be

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[96] *Ibid.*

[97] Welf. & Inst. Code, § 13757.

[98] For locally funded MHSA programs, see NAMI California, *2016 MSHA Programs: Services That Change Lives* (2016), *https://namica.org/wp-content/uploads/2016/06/NAMI-MHSA-Report-2016.pdf*.

[99] Cal. Dept. of Health Care Services, "Mental Health Services Act" (undated), *www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx*.

[100] Available at *www.cibhs.org/sites/main/files/file-attachments/fsp_tk_child_final_for_publication_9-20-11.pdf*.

[101] California Victim Compensation Board, *https://victims.ca.gov/victims/*.

eligible for Medi-Cal for Former Foster Youth until age 21. However, this program requires enrollment. Youth are only eligible for EPSDT benefits under Medi-Cal until age 21.

Assembly Bill 12 eligibility under category 5. There are five categories of eligibility for extended foster care, more commonly known as AB 12 (Fostering Connections to Success Act). A youth must maintain eligibility in one or more categories. If a youth is unable to attend school, work, a vocational program, or other programs that remove barriers to those programs, the youth may be eligible for AB 12 under category 5. To be eligible under this category, the youth must have a medical condition that prevents participation in the other eligibility categories.[102]

To establish the presence of a medical condition, the youth, with the support of the child welfare worker, probation officer, or the youth's attorney, may seek a letter from a health care practitioner. The letter can be provided to the social services agency. There is no requirement that the letter be provided to the court.[103] The letter does not waive the youth's physician-patient privilege, nor does it place the youth's medical condition "at issue" in the case for evidentiary purposes. The medical condition may also be established through the youth's receiving of SSI, disability benefits, or Regional Center services. The social services agency then certifies the youth's eligibility under category 5.[104]

Placements for nonminor dependents. Nonminor dependents with mental health or developmental needs may be placed in congregate care under certain circumstances. Youth under the age of 19 may remain in group care if it is in their best interest to complete high school or its equivalent. Youth with medical or mental health conditions may continue to stay in treatment programs if the treatment program functions as a short-term placement. Nonminor dependents with mental health, developmental, or physical disabilities may also be placed in an Adult Residential Facility (ARF). Nonminor dependents receiving mental health or substance abuse treatment may be placed in an Adult Treatment Facility (ATF). An ARF or an ATF can be approved as a Supervised Independent Living Placement (SILP). Though the nonminor may not receive SILP payments while in such programs, the nonminor may be able to receive funding through SSI. Nonminor dependents receiving Regional Center services may also be eligible for Regional Center group home placements.

Even for nonminor dependents, less restrictive alternatives to group care must be considered first. Placement in a treatment program should be a decision made by the Child and Family Team, with treatment goals and discharge planning included in the nonminor dependent's treatment plan.

Competency and capacity to make legal decisions as a nonminor dependent. This section addresses competency to direct legal counsel and capacity to make legal and medical decisions. For a

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[102] Welf. & Inst. Code, § 11403.

[103] Cal. Dept. of Social Services, All County Letter No. 11-69 (Oct. 13, 2011), Extension of Foster Care Beyond Age 18: Part One, p. 29, *www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-69.pdf*; All County Letter No. 11-61 (Nov. 4, 2011), Extended Foster Care (EFC), *www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-61.pdf*.

[104] *Id.*

discussion of competency to participate in a juvenile proceeding, see Section 10, Special Considerations for Juvenile Justice Cases, below.

If the court finds a nonminor dependent not competent to direct counsel, the court must appoint a guardian ad litem.[105] Questions regarding capacity to make medical or other legal decisions may suggest a need for a conservatorship. The probate court handles petitions for conservatorship.[106]

Crisis Services and Locked Facilities

Psychiatric hospitalizations, whether voluntary or involuntary, can be disruptive and traumatic. As psychiatric hospitals are locked facilities, they are a restrictive environment that can be used only when statutory criteria are met. Medical necessity criteria for Medi-Cal reimbursement for psychiatric hospitalizations is governed by California Code of Regulations, title 9, section 1820.205.

Mobile Crisis Services

Mobile crisis services vary between local jurisdictions and are not present in every county. Typically, such services include the availability for a mobile clinician or support staff to provide crisis intervention services.

Voluntary Hospitalization

If the youth is willing to be hospitalized for inpatient psychiatric treatment, an involuntary hospitalization is not required. The youth's parent, guardian, conservator, or other person with custody of the youth can apply to have the youth admitted voluntarily.[107] However, this is disfavored in cases where the youth's or the community's safety is at risk due to the youth's mental health diagnosis.

Involuntary Psychiatric Hospitalization

In limited circumstances, a dependent or ward may be admitted to a psychiatric hospital against the minor's wishes, as an *involuntary* patient. Psychiatric hospitalizations are a restrictive environment that should only be used when statutory requirements are met. Under Welfare and Institutions Code section 5585 or 5150, youth who are a danger to themselves or others or are gravely disabled may be held in a locked facility for assessment and treatment. Law enforcement or medical staff typically makes the initial assessment as to whether criteria are met.

If the court believes that a minor is or may be mentally ill, the court may order that the minor be held temporarily in a psychiatric or other approved hospital for observation and to obtain professional recommendations as to future care, supervision, and treatment.[108] However, the youth is still entitled to the due process protections provided in the Lanterman-Petris-Short Act for involuntary patients.[109] Law enforcement and medical professionals are typically in the best position to evaluate the youth's mental health status and safety risk because of the restrictive nature of psychiatric hospitalizations.

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[105] Welf. & Inst. Code, § 317(e)(1).

[106] Prob. Code, § 810 et seq.

[107] Welf. & Inst. Code, § 6000.

[108] Welf. & Inst. Code, §§ 357, 6550; Cal. Rules of Court, rule 5.645.

[109] *In re E.* (1975) 15 Cal.3d 183, 192 fn. 12.

After the completion of a 72-hour hold, if the professional person in charge of the facility finds that, as the result of mental disorder, the minor is in need of intensive treatment, the minor may be "certified" for not more than 14 days of involuntary treatment. At the end of this 14-day period, the professional in charge of the facility may recommend an additional stay of no more than 30 days. In a few circumstances, the professional in charge may be able to recommend an additional stay of no more than 180 days.[110]

Further involuntary treatment requires specialized court hearings compliant with the Lanterman-Petris-Short Act, appointment of a conservator, and a finding that the minor is gravely disabled.[111] In this context, "gravely disabled" means the youth cannot provide for his or her basic personal needs for food, clothing, or shelter, or, the court has found the youth to be mentally incompetent under Penal Code section 1370 and additional facts exist.[112]

In assessing whether a minor is gravely disabled for this purpose, the court must distinguish between disability and immaturity. As the California Supreme Court has explained, "[i]mmaturity, either physical or mental when not brought about by a mental disorder, is not a disability which would render a minor 'gravely disabled' within the meaning of section 5008."[113]

Juvenile Facilities

Youth can be detained in a locked juvenile facility only if booked or charged with a crime. Medi-Cal is often suspended while in a juvenile facility. There are exceptions, however, such as when a youth is on placement orders and in the facility awaiting placement.

Youth are entitled to mental health screening at intake and to an assessment if the screening indicates a need. They also are entitled to crisis intervention, stabilization and prevention of psychiatric deterioration, medication support, and transition planning for continuation of care in the community when they are receiving behavioral health services in the facility. They also may receive therapeutic and preventive care if resources permit.[114]

If the youth is being considered for foster care, the probation officer should commence a Child and Family Team.[115] The Child and Family Team may be held in juvenile hall, though the California Department of Social Services encourages this to occur outside the facility.[116]

Ordering Services

The court may join any governmental agency or private service provider in a proceeding by court motion if the agency is failing to meet a legal obligation to a youth, and the court may request that agency representatives meet before the hearing to coordinate provision of services. However, the

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[110] Welf. & Inst. Code, §§ 5260, 5270.15, 5300.

[111] Welf. & Inst. Code, § 5350.

[112] Welf. & Inst. Code, § 5008(h).

[113] *In re E.* (1975) 15 Cal.3d 183, 192 fn. 12.

[114] Cal. Code Regs., tit. 2, § 1437.

[115] Cal. Rules of Court, rule 5.785.

[116] Cal. Dept. of Social Services, All County Letter No. 18-23 (Jan. 1, 2018), The Child and Family Team (CFT) Process Frequently Asked Questions and Answers, *www.cdss.ca.gov/Portals/9/ACL/2018/18-23.pdf?ver=2018-06-01-160245-447*.

court has no authority to order services unless it has been determined, through the administrative process of an agency that has been joined as a party, that the youth is eligible for those services.[117]

7. Coordination of Services: Guiding Principles

Treatment is more than just receiving one health service. It is a package that requires keeping placement, community, and multiple services in mind. Frequently, the services a child needs are available through different programs that require coordination across systems to meet the unique needs of the particular youth. This also requires careful monitoring. There are several strategies to help support coordination of care efforts, including the Child and Family Team model.

Child and Family Team (CFT)

The Child and Family Team and the agency play an important role in coordinating services provided across systems and case planning. All minor and nonminor dependents are required by law to have periodic CFT meetings. A CFT also should be held for a ward being considered for a foster care placement. The youth's case plan should be informed by the CFT.[118] CFTs are facilitated by a trained facilitator who utilizes a team-based, family centered approach. Youth, family members, mental health providers, educators, social services, probation, and other natural supports are encouraged to attend CFT meetings. Ideally, CFTs take place in a home-like setting; however, they can also take place in psychiatric facilities or detention centers if required.[119] The youth's case plan and services must be based on input from the CFT.[120] CFTs also address critical needs that may arise in foster care cases. The outcome of a CFT is also used to support a youth's admission into an STRTP, as the youth's unique needs should be reflected in the services provided in a treatment setting, as well as in the transition plan to a less restrictive environment.[121]

Other notes on the CFT:[122]

- A child must have a meaningful opportunity to participate in the development of the case plan, and for youth 14 and older, the case plan must be developed in consultation with the youth and at least two adults of the youth's choosing.
- At least every six months and at each placement change, the worker must explain to each youth the youth's rights as a foster child, and provide the youth with a written copy.
- Placement decisions should be based on identifying the least restrictive placement that promotes normal childhood experiences.
- Pre-placement preventative services and reasonable efforts to prevent out-of-home placement should be documented at the CFT and in the case plan.

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[117] Welf. & Inst. Code, §§ 362(b), 727(b); Cal. Rules of Court, rule 5.575; *Notice of Hearing on Joinder—Juvenile* (form JV-540).

[118] Welf. & Inst. Code, § 706.6; Cal. Rules of Court, rule 5.785

[119] All County Letter No. 18-23, *supra.*

[120] Welf. & Inst. Code, § 16501.1(b)(1).

[121] All County Letter No. 18-23, *supra.*

[122] Welf. & Inst. Code, § 16501.1.

- Broader service needs are addressed at the CFT and in the case plan, including school of origin rights, Special Immigrant Juvenile Status eligibility and SSI applications.
- For youth age 10 and older, the CFT and the case plan should document that the youth has or will receive comprehensive sexual and reproductive health education as well as has access to such health care services and information.
- For youth ages 16 and older, the case plan should identify an adult to assist with financial aid and post-secondary education applications, unless the youth states they do not wish to pursue such education.

Timeline. CFTs must be held within 60 days of a youth entering foster care, whether through the probation or dependency system. At a minimum, CFTs should be held every six months. For youth or nonminor dependents receiving *Katie A.* services,[123] CFTs should occur every 90 days. A CFT may also be required if there is a pending change in placement, services, visits, transportation, or to address barriers in service coordination.

Service coordination. Providers from every agency engaged with the youth may participate in CFTs, including Regional Center service coordinators, and educational, medical, and mental health providers. This prevents duplication of services and supports a clear continuum of services.

Information exchange. Under Welfare and Institutions Code section 832, information disclosed in CFTs is confidential. Mental health clinicians and school representatives must comply with applicable confidentiality laws regarding when they may disclose health and education information to other members of a CFT. In most cases, an authorization to release information will be necessary. (For information on releases, see Section 9, Confidentiality, Privilege, and Sharing Information, below.) Local protocols inform the process for obtaining releases of information to share confidential information with other members of the CFT. Disclosure of privileged information to a CFT does not waive privilege. An authorization to release information to a CFT is not a waiver of therapist-patient privilege unless specifically stated.

Evaluating efficacy of CFTs

- Was the youth present at the CFT and able to participate? Were they informed of their rights as a foster child?
- Who else was present? Was it an accurate reflection of the youth's support system?
- Are the outcomes of the CFT reflected in the case plan and service delivery? If there are inconsistencies, are they sufficiently addressed?
- Are the outcomes of the CFT reflected in the STRTP placement and services?
- Were the statutorily required items addressed: Supplemental Security Income (SSI), Special Immigrant Juvenile Status, reproductive health, financial aid, etc.?

Multidisciplinary Team (MDT)

California law permits counties to form multidisciplinary teams to allow agencies to share confidential information to prevent child abuse or neglect. The team should include two or more persons that are trained in the prevention, identification, or treatment of child abuse and neglect. MDTs can include medical professionals, law enforcement, child welfare agencies, and schools.

[123] *Medi-Cal Manual*, *supra,* at p. 20.

Specific confidentiality protections are outlined by law.[124] County MDTs may also be formed to support specific at-risk youth populations, such as youth at risk for commercial sexual exploitation.[125]

8. Consent

Consent: General Rule

All nonemergency health care requires consent before treatment can be provided. When a patient is a minor child, a parent or legal guardian usually must consent for that child's medical treatment. When a child enters the dependency or the juvenile justice system, the general rule still holds: where the parent's or guardian's consent would have been required for services outside the system, the parent's or guardian's consent is necessary to receive those services inside the system.

The general rule has three important exceptions when youth enter the dependency or juvenile justice system:

- The juvenile court has the authority to remove a parent's right to consent to medical care once a minor is declared a dependent or ward of the court.[126] If the court exercises this authority and removes a parent's right to consent, the court must put that removal in a court order.[127]
- California law allows additional people to consent for a dependent's or ward's health care at times. This may include a social worker, probation officer, foster parent, or the court. This does not mean the parents or other person who holds primary consent rights have been divested of their authority.[128] Rather, the law simply provides additional options to ensure necessary services can be provided in a timely manner.
- There are special consent rules when a minor under court jurisdiction or court proceeding needs care in certain circumstances, in certain facilities, or needs certain types of specialty care. Minor consent rules also still apply. Some of these special rules are referenced in the next section.

Consent: Exceptions and Special Rules for Mental Health and Substance Use Disorder (SUD) Treatment

Minors have the right to consent to and/or the right to refuse:

- Outpatient mental health treatment at age 12 and older if a professional person deems the youth mature enough to participate intelligently in the services[129]
- SUD treatment at age 12 and older[130]

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[124] Welf. & Inst. Code, § 18961.7.

[125] Welf. & Inst. Code, § 16524.6 et seq.

[126] Welf. & Inst. Code, §§ 361(a), 726(a).

[127] *Ibid.*

[128] Welf. & Inst. Code, §§ 369(f), 739(f).

[129] Health & Saf. Code, § 124260; Fam. Code, § 6924; Welf. & Inst. Code, § 369(h).

[130] Fam. Code, § 6929; Welf. & Inst. Code, § 369.

- Voluntary hospitalization[131]
- Welfare and Institutions Code section 711 evaluation[132]
- Medication in certain placements[133]

The court must authorize certain services at times, including:

- Involuntary hospitalization[134]
- Psychotropic medication[135]
- Emergency services[136]

These rules and exceptions are described in more detail in *Consent to Medical Treatment for Foster Children: California Law* and *Consent to Medical Treatment for Youth in the Juvenile Justice System: California Law*.[137]

Consent: Mental Health or SUD Treatment as a Condition of Probation

When the court places a youth on probation, it "may impose on the ward any and all reasonable conditions of behavior as may be appropriate under this disposition."[138] Courts can order youth to participate in certain health care services as a condition of probation.[139] In some cases, courts have ordered or conditioned probation on a youth attending mental health counseling.[140] In others, courts have made drug testing and attending substance abuse treatment a probation condition. For example, if the court does not remove a youth from his or her parents' physical custody, the court may require as a condition of probation that the youth submit to urine alcohol and drug testing upon the request of a peace or probation officer.[141]

Similarly, the court may require the youth to participate in, and complete, an alcohol or drug education program.[142] However, this order making counseling, testing, or other treatment a condition of probation is not the same as authorizing or consenting to services. Consent is still

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[131] Welf. & Inst. Code, § 6552.

[132] Welf. & Inst. Code, § 711.

[133] E.g., Welf. & Inst. Code, § 5332.

[134] E.g., Welf. & Inst. Code, §§ 357, 705; but see *In re E.* (1975) 15 Cal.3d 183, 192 fn. 12.

[135] Welf. & Inst. Code, §§ 369.5, 739.5.

[136] Bus. & Prof. Code, § 2397.

[137] Gudeman, *Consent to Medical Treatment for Foster Children: California Law* (National Center for Youth Law, Feb. 2014), https://youthlaw.org/wp-content/uploads/2015/11/Consent-to-Medical-Care-Foster-Care-2-5-14.pdf; Gudeman, *Consent to Medical Treatment for Youth in the Juvenile Justice System: California Law* (National Center for Youth Law, Nov. 2009), http://teenhealthlaw.org/wp-content/uploads/2015/10/Juv._Justice_Consent_Manual_11-09.pdf.

[138] Welf. & Inst. Code, § 727(a).

[139] E.g., *In re Luis F.* (2009) 177 Cal.App.4th 176 (discussing when probation conditions ordering treatment, in this case a medication condition, may infringe on constitutional rights).

[140] For example, the court may order a ward and his or her family to "participate in a program of professional counseling." Welf. & Inst. Code, § 731(a).

[141] Welf. & Inst. Code, § 729.3.

[142] Welf. & Inst. Code, §§ 729.10, 729.12.

necessary to provide treatment, and where the youth's consent is necessary to provide that treatment, the youth may refuse. While a minor may refuse to consent to or choose not to attend court-ordered treatment, there may be consequences. For example, in one case, a ward's refusal to participate in court-ordered drug treatment became the basis for the court's decision to commit the ward to a Youth Authority facility.[143] If a youth has concerns about any court-ordered treatment, the youth should immediately discuss these concerns with their attorney or another trusted advocate.

9. Confidentiality, Privilege, and Sharing Information

Both confidentiality and privilege control disclosure of health information. Confidentiality statutes control release of individually identifiable health information from a health provider to a third party and additionally may limit third parties from re-disclosing the information to others. Privilege statutes create a presumption that disclosure of a patient's confidential communications with a health provider as evidence in a court setting is barred unless waived by the patient. Confidentiality and privilege operate independently. Anytime health information may be entering the court, both confidentiality and privilege must be considered.

Written Authorizations for Release of Information

The confidentiality of information and records created by a health care provider who has provided substance use or mental health evaluations and/or services is protected by both federal and state confidentiality laws.[144] As a general rule, a provider cannot disclose any protected health information without a written authorization.[145] This authorization must include certain elements to be valid.[146]

Generally, a parent or guardian signs that authorization for a minor patient.[147] However, the parent cannot sign in the following situations:

- The minor must sign the release when the minor is 12 or older and the records relate to substance abuse treatment or outpatient mental health services to which the minor could have consented.[148]
- The parent can no longer sign on behalf of the minor once a minor has been removed from the custody of their parent or guardian in dependency, unless the juvenile court explicitly issues an order authorizing the parent to sign. The court may issue this order only after finding that it would not be detrimental to the minor.[149]

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[143] *In re Anthony M.* (1981) 116 Cal.App.3d 491, 504.

[144] Applicable laws may include, but are not limited to, the Privacy Rule of the federal Health Insurance Portability and Accountability Act (HIPAA), the federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act (CAAPTR), and California's Confidentiality of Medical Information Act (CMIA) and Lanterman-Petris-Short Act (LPS).

[145] 45 C.F.R. §§ 164.502(a)(1), 164.508(a)(1); Civ. Code, § 56.11; Welf. & Inst. Code, § 5328(a).

[146] 42 C.F.R. § 2.31; 45 C.F.R. § 164.508(c); Civ. Code, § 56.11.

[147] 45 C.F.R. § 164.502(g); Civ. Code, § 56.11(c); Welf. & Inst. Code, § 5328(d).

[148] 42 C.F.R. § 2.14; Civ. Code, § 56.11.

[149] Civ. Code, § 56.106; Welf. & Inst. Code, § 5328.03.

Exceptions to Requirement for an Authorization

There are exceptions in every confidentiality law that allow health providers to disclose information to third parties even where there is no written authorization in place. Depending on the applicable laws, the exceptions are different; however, common exceptions require or allow disclosures pursuant to a court order, between providers to coordinate care or referrals for a common patient, in emergencies, and for securing payment.[150] In some cases, recipients of information are restricted from further disclosing the information unless the disclosure is authorized by the confidentiality law.[151] It is important to understand which confidentiality laws apply to information and records in order to understand the applicable exceptions. For example, some substance use disorder treatment information is strictly confidential and cannot be disclosed, even to the court, without the appropriate authorization or specialized court order in place.[152] These rules and exceptions are described in more detail in the "Sharing Information" briefings available from the Judicial Council of California.[153]

Special Rules When Youth Removed from Parent Custody in Dependency

When a minor has been removed from the custody of their parent or guardian in dependency, a psychotherapist is not permitted to release the minor's mental health records or mental health information to the parent. The parent also loses the right to sign authorizations to release the minor's mental health information to third parties. However, the court may issue an order authorizing the parent to sign authorizations. The court may issue this order only after finding that it would not be detrimental to the minor.[154]

Privilege: Testimony, Case Plans, Court Reports, and Other Evidence

California law gives patients the "privilege" to refuse to disclose and to prevent their health providers from disclosing "confidential communications" for use as evidence in court, even if the disclosure is otherwise authorized by applicable confidentiality law.[155] When a health provider is asked to disclose information that may be used as evidence in court, the provider is required to claim privilege on behalf of their patient unless they know privilege has been waived.[156]

In dependency cases, privilege may be waived by the child if the child is of sufficient age and maturity, and in other cases, by the child's attorney. A child is presumed of sufficient age and

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[150] E.g., 45 C.F.R. §§ 164.502(a)(1)(ii), 164.512; Civ. Code, § 56.10(b) & (c).

[151] Civ. Code, § 56.13.

[152] 42 C.F.R. §§ 2.1(b), 2.2(b), 2.64.

[153] Judicial Council of Cal./Administrative Office of the Courts, "Sharing Information About Children in Foster Care: Mental Health Care Information" (Aug. 2010) *AOC Briefing*, *www.courts.ca.gov/documents/BTB24-3H-7.pdf*; Administrative Office of the Courts, "Sharing Information About Children in Foster Care: Substance Abuse Treatment Information" (Aug. 2010) *AOC Briefing*, *www.courts.ca.gov/documents/BTB24-3H-8.pdf*. Second editions are forthcoming from the Judicial Council of California.

[154] Civ. Code, § 56.106; Welf. & Inst. Code, § 5328.03.

[155] Evid. Code, § 1014.

[156] Evid. Code, § 1015.

maturity to invoke or waive privilege at age 12. Neither the court nor a parent may waive privilege for a dependent child.[157]

Addressing psychotherapist-patient privilege in the juvenile context, courts have held that even if psychotherapist-patient privilege applies, certain circumscribed mental health information nevertheless may be included in reports submitted to the court from the child welfare and probation agency; however the extent of the information, if any, that may be included in a court report without violating privilege will vary based on the specifics of the case.[158] This is an evolving area of law and is described in more detail in the Judicial Council briefing.[159]

Confidentiality and Privilege: Common Areas of Concern and Challenge

Examples of common areas of challenge include the following:

- Disclosures in a case plan, court report, or testimony without appropriate authorization and/or when the minor has not waived privilege.
- Disclosures in a Child and Family Team without appropriate authorizations.
- Disclosure of SUD information protected by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (CAAPTR) without a CAAPTR-compliant authorization or court order that satisfies requirements of CAAPTR.
- Sharing information with parents when a minor has been removed from parental custody in dependency, including sharing information in a CFT that includes parental involvement, with no court order authorizing the disclosure.
- Re-disclosures by an agency or other third parties without appropriate authorizations.
- Requiring disclosures to monitor compliance with the conditions of probation.

The resources listed below provide additional insight and information regarding these issues.

Additional Resources

- Gudeman, *Consent to Medical Treatment for Foster Children: California Law*[160]
- Gudeman, *Consent to Medical Treatment for Youth in the Juvenile Justice System*[161]
- Judicial Council of California, *Sharing Mental Health Information for Children in Foster Care* (2d ed., forthcoming)
- Judicial Council of California, *Sharing Substance Abuse Information for Children in Foster Care* (2d ed., forthcoming)

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[157] Welf. & Inst. Code, § 317(f).

[158] See *In re Kristine W.* (2001) 94 Cal.App.4th 521, 528; see also *In re Christopher M.* (2005) 127 Cal.App.4th 684, 696 and *In re Pedro M.* (2000) 81 Cal.App.4th 550, 554; but see *People v. Gonzales* (2013) 56 Cal.4th 353, 375 fn. 6 (disapproving any language in *In re Christopher M.* and *In re Pedro M.* that suggests language in Evidence Code section 1012 creates an *exception* to privilege in certain circumstances).

[159] Judicial Council of Cal., *Sharing Mental Health Information for Children in Foster Care* (2d ed., forthcoming).

[160] Available at https://youthlaw.org/wp-content/uploads/2015/11/Consent-to-Medical-Care-Foster-Care-2-5-14.pdf.

[161] Available at http://teenhealthlaw.org/wp-content/uploads/2015/10/Juv._Justice_Consent_Manual_11-09.pdf.

10. Special Considerations for Juvenile Justice Cases

Youth in the juvenile justice system often come from similar circumstances as youth in the dependency system. As such, they may have similar trauma history, unmet mental health needs, and may be at risk for future placement instability and challenges in school. Nearly all community-based services, school-based services, and other mental health service entitlements listed above also apply for youth in the juvenile justice system.

Similarly, trauma-informed and culturally competent courtroom practices with youth in the juvenile justice system are necessary to prevent re-traumatization, increase youth buy-in for the probation process, and to properly address environmental factors that impact recidivism. Youth encountering the probation system should be screened for unmet mental health needs. Successful juvenile justice collaboration also includes utilization of CFTs and other teams to support the youth's progress. Finally, youth in juvenile justice cases should be in the least restrictive environment to address their rehabilitative goals and the protection of society.

Inquiry Regarding Presenting a Juvenile Justice Case

Unaddressed mental illness symptoms and trauma symptoms can sometimes present as antisocial behavior. To evaluate whether mental health may be a factor in the offense presented to the court, consider the following:

- *For incidents that occur at home:* Family relationships can trigger mental health conditions, especially if the youth has experienced trauma in the home. The family also may not have an understanding of or services to support the youth's needs.

- *For incidents that occur in STRTPS:* These programs have a legal obligation to create a crisis management assessment that includes techniques for de-escalation. The staff may have not created or adhered to the crisis escalation plan or the youth may not have been receiving otherwise required mental health treatment.[162]

- *For incidents that occur at school:* The school has legal obligations to support a youth who is eligible for an IEP or 504 plan. If a youth is receiving school-based mental health services or is eligible for an IEP/504 plan on the basis of their emotional disturbance, they may receive additional services designed to address mental health symptoms. For incidents that result in a youth with an IEP facing extended suspension or expulsion, the school is required to hold a manifestation determination hearing to determine whether the youth's behavior was caused by the disability for which they are receiving supportive services.

- Was the incident a survival skill or self-medication? Youth who are using substances or destroying property may be doing so in a misdirected attempt to treat underlying mental health conditions.

[162] Cal. Dept. of Social Services, Short-Term Residential Therapeutic Program, *Interim Licensing Standards* (Jan. 11, 2019) p. 117.

- Was the incident connected to the youth's victimization by commercial sexual exploitation? Some behaviors, such as providing a false name to a police officer, stem from a youth's sexual exploitation victimization.

Tailored Probation Terms and Conditions

Probation terms provide an opportunity to address underlying conditions or circumstances that led to a youth's offense. If a youth presents with a mental health need, probation terms can be tailored to provide treatment. Prior to referring for mental health treatment, the youth should be evaluated by a mental health professional to identify the youth's specific needs and also to create buy-in with the youth about what their goals are for treatment. Further, to maximize the potential for success, treatment conditions should be set that are relevant, reasonable, and achievable in a short time. If treatment is unavailable or if it cannot be provided during the period of probation, other more measurable alternatives should be considered. For youth placed in STRTPs or foster placements, the placement may provide mental health services and additional treatment may not be helpful or necessary.

Probation terms need to be individualized and should consider the youth's developmental and intellectual capacity. When the court is ordering specific terms, special care should be taken to ensure the youth understands what is expected of probation. Trauma, stress, and illness may impact the youth's comprehension. Harm reduction should be considered rather than absolutism (e.g., if a youth is self-medicating with marijuana, reduction rather than complete elimination should be supported).

Finally, proper consent should be obtained for treatment. For example, if the court is ordering drug treatment, minors 12 and older must consent for the care. Even if treatment is court ordered, most disclosures to the court require waiver of psychotherapy-patient privilege as well as a signed authorization or exception under applicable confidentiality law. Authorizations to release information or orders in place should balance the importance of honoring confidentiality with the need to monitor compliance with a treatment-related probation condition.[163]

Competency to Participate in Proceeding

The court must suspend proceedings and appoint an expert to conduct an evaluation if there is substantial evidence that the youth lacks competency to participate in the proceeding.[164] While this evaluation should include relevant diagnoses and disabilities, it is not the same as, nor a substitute for, a non-forensic psychological evaluation. Competency in this context is not the same as competency to direct legal counsel nor is it the same as capacity to make health care decisions. A youth or young adult may lack competency to participate in a court proceeding but have the capacity to make health decisions, or vice versa.

[163] See *People v. Gonzales* (2013) 56 Cal.4th 355, 375 (addressing privilege in context of court-mandated therapy in adult context).

[164] Welf. & Inst. Code, § 709; Cal. Rules of Court, rule 5.651(c).

Glossary of Terms

Child and Family Team (CFT): CFTs are a strengths-based, family-centered meeting that generally includes the youth and members of the youth's family, team, and community who are important to the youth or who are providing mental health services. CFTs are integral to both *Katie A.* services and to Continuum of Care Reform (CCR). They contain overlapping principles of decision-making and inclusion of a broader team but are triggered/required on different timelines and may have different purposes. For example, a CCR CFT is required when a youth enters foster care or when a placement change is pending for a system-involved youth. A *Katie A.* CFT is specific to the services included under *Katie A.*

Core Practice Model (CPM): The set of principles and values that guide work with youth and families involved in the mental health systems. Some of the specific values include the following: services should be needs based, strengths driven, and family focused; services should be individualized to the youth/family; services are delivered through multiagency collaboration; emphasis on family voice and choice; blending of informal and formal resources; and services should be culturally competent.[165]

***Diagnostic and Statistical Manual of Mental Disorders (DSM)*:** A manual published by the American Psychiatric Association which provides common language and standardized criteria for classifying and diagnosing mental disorders. The fifth edition *(DSM-V)* was published in 2013.

Educationally Related Mental Health Services (ERMHS): Mental health services that must be provided to children who require mental health services as a part of their IEP or 504 plan; formerly "AB 3632" services.

Emily Q.: As a result of the decision in *Emily Q. et al. v. Belshe et al.*, the California Department of Mental Health and local Mental Health Plan agencies are required to increase utilization of Therapeutic Behavioral Services in California. Eligibility criteria was established under the settlement: youth under 21 who are receiving EPSTD services who are placed or have been considered being placed in a level 12 or higher group home, or have been psychiatrically hospitalized in the last 24 months or at risk of psychiatric hospitalization.

Emotional disturbance: A youth may qualify for an Individualized Education Plan under emotional disturbance if, upon examination by a school psychologist, the child is found to have one or more of the following conditions: an inability to learn that cannot be explained by intellectual sensory or health factors; an inability to build or maintain satisfactory interpersonal relationships; inappropriate types of behavior or feelings under normal

[165] Cal. Dept. of Health Care Services & Cal. Dept. of Social Services, *Pathways to Mental Health Services: Core Practice Model Guide* (undated), www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf.

circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears.

"Evidence-based" versus "evidence-informed": Evidence-based *practices* are approaches to prevention or treatment that are validated by some form of documented scientific evidence. This includes findings established through controlled clinical studies, but other methods of establishing evidence are valid as well. Evidence-*informed* practices use the best available research and practice knowledge to guide program design and implementation. This informed practice allows for innovation while incorporating the lessons learned from the existing research literature. Ideally, evidence-based and evidence-informed programs and practices should be responsive to families' cultural backgrounds, community values, and individual preferences."[166]

Intensive Care Coordination (ICC): Oftentimes, youth with mental health needs have many providers. The coordinator assists in managing these providers, facilitating assessment, care planning, and coordination of services for the youth. The coordinator works with the *Katie A.* CFT to provide feedback and get recommendations for services.[167]

Intensive Home Based Services (IHBS): Services designed to support the youth's functioning in the home and community. Such services should be individualized and targeted to increase the youth's functioning.[168]

Intensive Services Foster Care (ISFC): ISFC is home-like care for youth with intensive mental health or medial needs who need additional supervision and support. ISFC homes are designed to prevent placement of youth with high needs into congregate care settings. Foster family agencies are required to design recruitment and training strategies to support ISFC parents.[169]

***Katie A.* services:** As a result of the settlement agreement in *Katie A. v. Bonta*, all youth under the age of 21 who have full-scope Medi-Cal and meet medical necessity criteria for Specialty Mental Health Services can receive *Katie A.* services under EPSDT. *Katie A.* services are a wraparound model that includes Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care.[170] The *Katie A.* services include use of a Child and Family Team that meets at least every 90 days and is guided by the Core Practice Model.

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[166] Child Welfare Information Gateway, U.S. Dept. of Health & Human Services, "Evidence-Based Practice Definitions and Glossaries" (undated), *www.childwelfare.gov/topics/management/practice-improvement/evidence/ebp/definitions/*.

[167] Cal. Dept. of Social Services, *Medi-Cal Manual For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TF) Services for Medi-Cal Beneficiaries* (Jan. 2018), p. 23, *www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf*.

[168] *Id.* at p. 30.

[169] Welf. & Inst. Code, §§ 18360, 18360.06, 18360.10; Cal. Dept. of Social Services, All County Letter No. 18-25 (Apr. 30, 2018), State Guidance for Specialized Pay Rate (SCR) Programs.

[170] *Medi-Cal Manual*, *supra,* at p. 6.

Medical necessity: Welfare and Institutions Code section 14059.5 states that "[a] service is 'medically necessary' or a 'medical necessity' when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." Medical necessity criteria are defined slightly differently depending on the types of service being provided:

- Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services (Cal. Code Regs., tit. 9, § 1820.205).
- Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age (Cal. Code Regs., tit. 9, § 1830.210).
- Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services (Cal. Code Regs., tit. 9, § 1830.205).

Medical Necessity for Specialty Mental Health Services: For a youth to be deemed eligible for Specialty Mental Health Services under Medi-Cal, the youth has to be diagnosed, the treatment provided has to be focused on and expected to diminish the impairment caused by the diagnosis, and the condition would not be responsive to physical health treatment.[171]

Resource Family: A caregiver who has completed the current state licensing process. A relative or family friend usually is given first priority for placement.

Resource Family Approval (RFA): The statewide process for relatives or family friends to be authorized and paid as caregivers to court-involved youth. RFA requires extensive background checks and attendance at informational classes.

Serious emotional disturbance: Minors under the age of 18 years who have a mental disorder as identified by the *DSM*, other than a substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms and either (1) has substantial impairment in at least two areas: self-care, school functioning, family relationships, ability to function in the community; and either is at risk of removal from the home or has already been removed or the mental disorder and impairment has been present for six months and is likely to persist for more than a year without treatment; or (2) displays one of the psychotic features, risk of suicide, or risk of violence due to the mental health disorder.[172]

Special Immigrant Juvenile Status (SIJS): Children who are in the United States and have been abused or neglected by a parent may be eligible for SIJS, a legal status that is a pathway to legal permanent residence.

[171] Cal. Code Regs., tit 9, § 1830.210.

[172] Welf. & Inst. Code, § 5600.3.

Substance Use Disorder (SUD): Individuals may be diagnosed with an SUD or a Mental Health Substance Use Disorder (MHSUD).

Therapeutic Foster Care (TFC): Short-term, intensive, highly coordinated, trauma-informed, and individualized intervention provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. This service may not be available in all counties, or its availability may be limited. TFC parents must be certified as Resource Parents, have additional and ongoing training, and meet additional criteria to be certified.

Therapeutic Behavioral Services (TBS): Wraparound services available to youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.[173] Services are intensive, individualized, one-to-one, and tend to be short term and focused on preventing psychiatric hospitalization.

Wraparound services: "Wraparound" is a philosophy of community-based support for youth with mental health needs. In contrast to a 50-minute, office-based therapeutic approach to mental health treatment, wraparound services are holistic, adaptable to the needs of the youth and family, and inclusive of the child's natural supports.

[173] Cal. Dept. of Health Care Services, *Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment*, *www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/Info_Notice/MC003_ENG.pdf*.

Appendix I: Types of Mental Health Professionals

- **Licensed clinical social worker (LCSW).** An LCSW must have a master's degree in social work, 3,000 hours of supervised clinical work, and pass a licensing exam to be licensed as a clinical social worker. An LCSW can work as a clinician providing therapy services.

- **Licensed marriage and family therapist (LMFT).** An LMFT must have a master's degree in marriage and family therapy, 3,000 hours of supervised clinical work, and pass a licensing exam. An LMFT can work as a clinician providing therapy services.

- **Licensed psychologist.** A psychologist must have obtained a doctoral degree in psychology, educational psychology, or education with a specialization in counseling or educational psychology. Licensure also requires 3,000 supervised hours and successfully passing psychology-specific licensing exams. Licensure is governed by the Department of Consumer Affairs Board of Psychology.

- **Neuropsychologist.** Neuropsychologists are licensed psychologists who specialize in how behavior and cognitive ability relate to the functioning of the brain. They may have either a PhD or a PsyD and most have completed postdoctoral training in neuropsychology. Pediatric neuropsychologists have done postdoctoral training in testing and evaluation.[174]

- **Psychiatric nurse practitioner.** A psychiatric nurse practitioner is licensed to prescribe psychotropic medications generally; however, Welfare and Institutions Code section 369.5, which governs the administration of psychotropic medications to foster youth, requires that only a physician can prescribe medication to foster youth.

- **Psychiatrist.** Psychiatrists must complete medical school, including a residency. In addition to prescribing medications, psychiatrists are trained to interview and examine patients, diagnose mental health conditions, and provide inpatient and outpatient therapy. "Child and adolescent psychiatrists are MDs who are fully trained in general psychiatry and then have at least two more years of training focused solely on psychiatric disorders arising in childhood and adolescence, including developmental disorders."[175]

- **School psychologist.** "School psychologists are trained in psychology and education and receive a Specialist in School Psychology (SSP) degree. They can identify learning and behavior problems, evaluate students for special education services, and support social, emotional, and behavioral health."[176] School psychologists typically work for a

[174] Child Mind Institute, "Guide to Mental Health Specialists" (undated), *https://childmind.org/guide/guide-to-mental-health-specialists/*.

[175] *Ibid.*

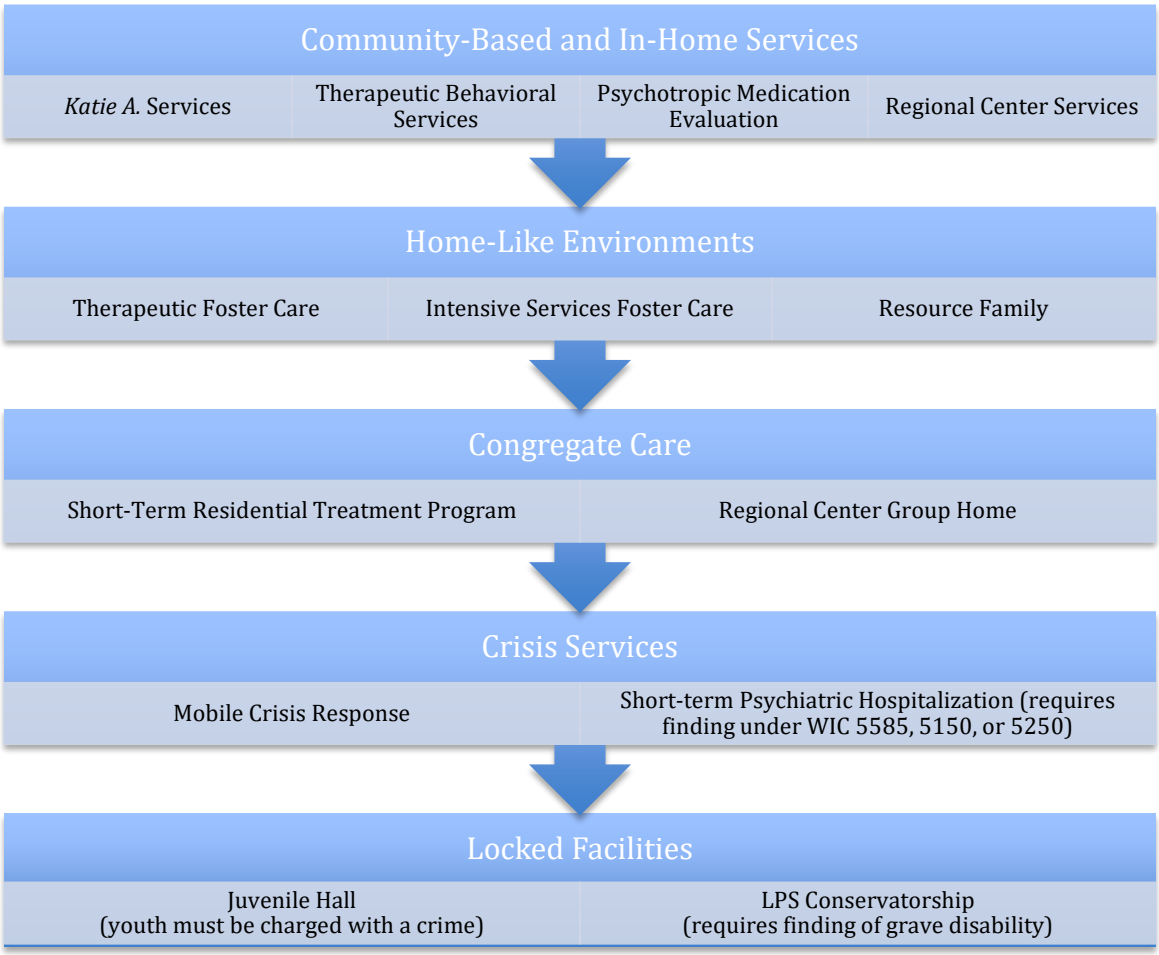
[176] *Ibid.*

school system and are often responsible for psychological evaluations completed by a public school in the course of assessing eligibility for a 504 plan or an IEP.

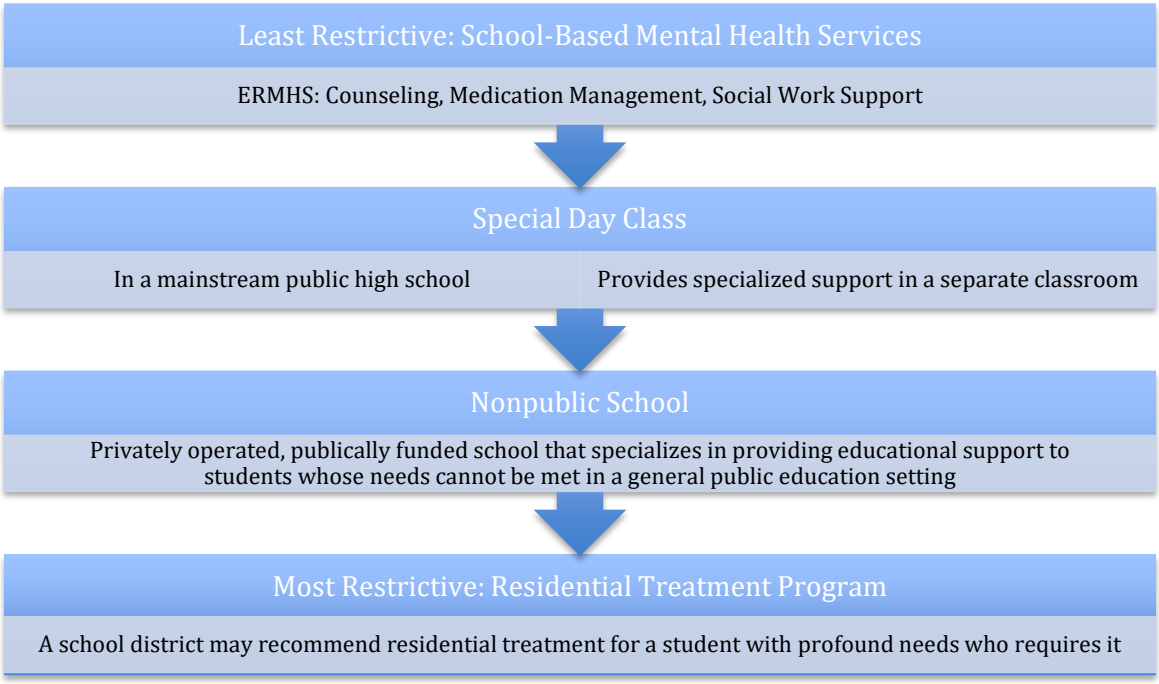
- **Other mental health providers.** Other community-based case managers, family partners, and advocates can provide case management services but are not licensed to conduct therapy.

Appendix II: Flow Charts of Services

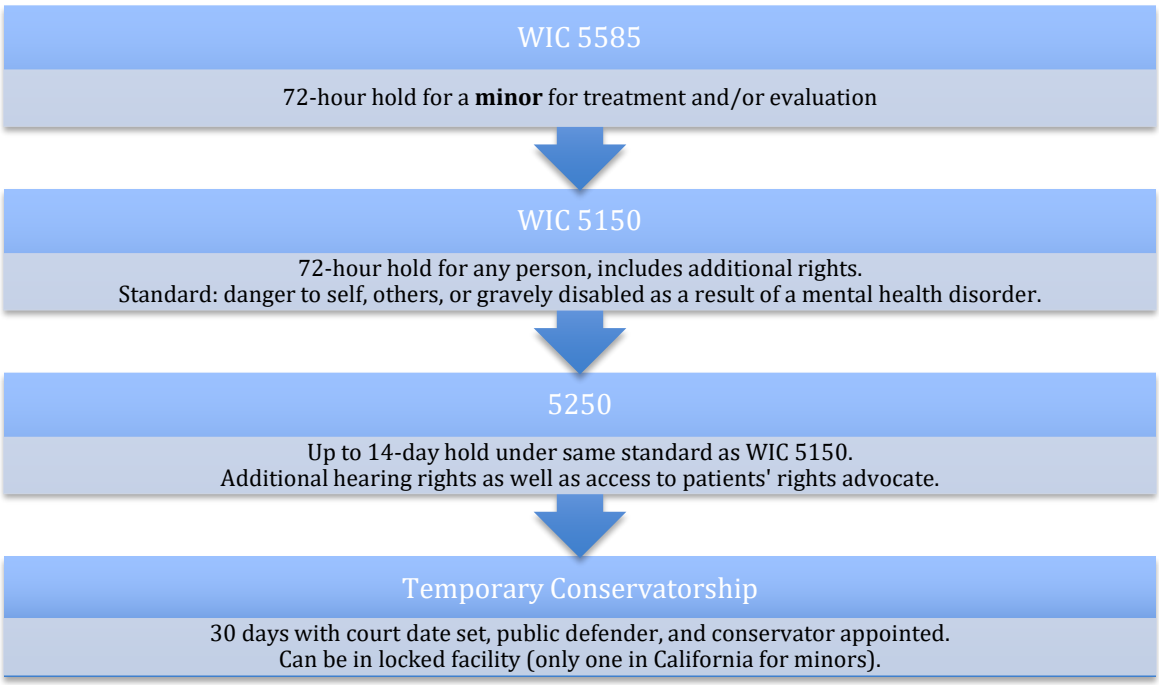
COMMUNITY-BASED SERVICES FLOW CHART



SCHOOL-BASED SERVICES FLOW CHART



CRISIS SERVICES FLOW CHART



Appendix III: Common Diagnoses

Table 1:

Common School-age Child and Adolescent DSM-IV-TR Diagnoses

Mood Disorders	
• Depression • Depression with psychotic features • Bipolar disorder	Mood disorders are a group of disorders that reflect disturbances in mood stability. Mood issues are the primary feature of the disturbance and children/teens seem stuck in a cycle of depressed mood as in depression or fluctuate their moods quickly, from depressed to euphoric or angry, as in bipolar disorder.
Anxiety Disorders	
• Obsessive-compulsive disorder • Post traumatic stress disorder • Generalized anxiety disorder	With anxiety disorders, the underlying feature is rooted anxiety. This can be a general state where anxiety is present fairly consistently as in generalized anxiety disorder, where the anxiety is manifested in repetitive behaviors or chronic worries as in obsessive compulsive disorder, or the anxiety is generated by a trauma or extreme stressor has triggered other symptoms such as hypervigilance and nightmares as in post traumatic stress disorder.
Thought Disorders	
• Schizophrenia • Psychotic disorder	Thought disorders are those that interfere with coherent, rational thinking and the ability to process incoming information and events. There can be disturbances in thinking and the ability to make sense of things. There can also be additional symptoms, such as visual hallucinations, hearing voices, or believing things are happening when they are not.
Attention-Deficit and Disruptive Behavior Disorders	
• Attention-deficit hyperactivity disorder • Conduct disorder • Oppositional defiant disorder	This group of disorders is rooted in the ability to manage one's behavior and attention. ADHD is related to the ability to pay attention, prioritize, and process information. Conduct disorder is essentially a disregard for rules and authority figures and may involve criminal involvement. Oppositional defiant disorder is generally a reluctance to follow caregiver rules or school rules.
Elimination Disorders	
• Enuresis • Encopresis	These disorders involve an inability to manage one's elimination of either urine or stool after successful potty training. The underlying issues often involve anxiety or trauma.
Other Disorders of Infancy, Childhood or Adolescence	
• Separation anxiety disorder • Reactive attachment disorder • Anorexia • Bulimia	Separation anxiety disorder is rooted in difficulty separating from a caregiver. Reactive attachment disorder reflects a traumatized pattern of relationships. Anorexia/bulimia are eating disorders that often first appear in adolescents.

Note: the DSM-IV-TR refers to the Diagnostic Statistical Manual of Mental Disorders IV, Text Revision

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Source: Solchany, "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges" (Oct. 2011) *Practice & Policy Brief* (ABA Center on Children and the Law), p. 5.

Appendix IV: Common Treatments

A Multimodal Approach to Managing Mental Health Disorders in Children

Managing mental health issues and the symptoms experienced by children and adolescents involves many modalities:

- **Medication treatment, or psychopharmacology**, can alleviate or lessen the symptoms that accompany many mental health disorders. For example, medication may decrease the impulse to tantrum, help a child regulate physiologic responses to emotions, or eliminate auditory hallucinations. In addition, proper medication support can provide behavioral stability and support with emotional regulation that a child or teen may need to readily engage in other forms of therapy. For example, a very depressed teen who cannot control her crying when she needs to be able to talk about her abuse and history can feel more in control emotionally with the right medication, allowing her to discuss the important issues and aid in her healing.
- **Behavioral therapy**, for example using reward charts, can help increase positive behaviors and decrease negative acting out.
- **Cognitive behavioral therapy** can help correct a pattern of negative thoughts that interfere with the ability to relate to others.
- **Play therapy** can help heal past trauma and facilitate a child's return to normal functioning.
- **Child-parent psychotherapy** involves working directly with the parent and child to address issues within their relationship and help the child increase healthy ways of interacting and functioning. Parents are helped to become more reflective, develop a deeper understanding of their child and their role in their child's life. They also learn how to interact with their child in ways that promote a healthy and secure attachment and to support a healthy growth and development trajectory. Parent coaching can also be an element of this modality.
- **Dialectical behavioral therapy (DBT)** can provide important skills, such as distress tolerance and emotional regulation, in struggling adolescents and help them integrate them into their daily interactions.

All of these treatments are valid and can help manage symptoms, facilitate healing, and return children to optimal functioning.

Managing mental health issues and the symptoms experienced by children and adolescents involves many modalities.

Source: Solchany, "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges" (Oct. 2011) *Practice & Policy Brief* (ABA Center on Children and the Law), p. 7.

Appendix V: Common Psychotropic Medications

Psychotropic Medications

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Antidepressants	SSRIs (Selective Serotonin Reuptake Inhibitors)	• Citalopram (Celexa) • Escitalopram (Lexapro) • Fluoxetine (Prozac)* • Fluvoxamine (Luvox) • Paroxetine (Paxil) • Sertraline (Zoloft)	• Headache • Agitation • Nervousness • Feeling emotionless • Decreased appetite • Suicidal ideation • Stomach upset • Fatigue • Sexual dysfunction	Symptoms of depression including depressed mood, lethargy, anhedonia, inability to sleep, excessive sleep, and isolation/withdrawn behavior; can also be used in the treatment of anxiety. *Only antidepressant approved for use in children age 8 and older for depression
	Tricyclics	• Clomipramine (Anafranil) • Amitriptyline (Elavil) • Desipramine (Norpramin) • Imipramine (Tofranil) • Doxepin (Sinequan)	• Stomach upset • Headache • Tiredness • Appetite increases • Dry mouth • Urinary retention • Dizziness/drop in blood pressure when going from sitting to standing	
	MAOIs (Monoamine oxidase inhibitors)	• Phenelzine (Nardil) • Tranylcypromine (Parnate)	• Sleepiness • Dizziness • Feelings of skin prickling • Insomnia • Dry mouth • Diarrhea • Nervousness • Muscle aches • Weight gain • Sexual dysfunction • Blood pressure changes	
	Others	• Trazodone (Desyrel) • Venlafaxine (Effexor) • Mirtazapine (Remeron) • Nefazodone (Serzone) • Bupropion (Wellbutrin)	• Seizures • Headache • Appetite changes • Restlessness • Agitation • Hostility • Dizziness	
Antipsychotics	Typical	• Haloperidol (Haldol) • Loxapine (Loxitane) • Thioridazine (Mellaril) • Thiothixene (Navane) • Fluphenazine (Prolixin) • Mesoridazine (Serentil) • Trifluoperazine (Stelazine) • Chlorpromazine (Thorazine) • Perphenazine (Trilafon)	• Weight gain • Involuntary repetitive movements • Agitation • Dizziness • Excess salivation • Lowered white blood cell count • Sexual dysfunction • Joint stiffness • Tardive dyskinesia	Thought disorders such as schizophrenia and psychosis; symptoms such as hallucinations, delusions, impaired judgment, severe difficulty with social interaction, loose associations, and paranoia.

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Psychotropic Medications (continued)

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Antipsychotics	Atypical	• Aripiprazole (Abilify) • Clozapine (Clozaril) • Ziprasidone (Geodon) • Risperidone (Risperdal) • Quetiapine (Seroquel) • Olanzapine (Zyprexa)	• Weight gain • Agitation • Sexual dysfunction • Tiredness • Lactation • Sleepiness • Heart problems • Stiffness	Thought disorders such as schizophrenia and psychosis; symptoms such as hallucinations, delusions, impaired judgment, severe difficulty with social interaction, loose associations, and paranoia.
Anti-anxiety		• Lorazepam (Ativan) • Buspirone (BuSpar) • Prazepam (Centrax) • Propranolol (Inderal) • Clonazepam (Klonopin) • Escitalopram (Lexapro) • Chlordiazepoxide (Librium) • Oxazepam (Serax) • Atenolol (Tenormin) • Clorazepate (Tranxene) • Diazepam (Valium) • Alprazolam (Xanax) • Guanfacine (Tenex) • Diphenhydramine (Benadryl) • Catapres (Clonidine) • Hydroxyzine (Vistaril)	• Confusion • Sleepiness • Agitation • Hallucinations • Fear • Psychosis • Rage • Memory impairment • Slurred speech • Lethargy • Spaciness • Disorientation • Suicidal ideation	Symptoms including racing thoughts, feelings of overwhelming dread, rumination, excessive worry, excessive fear, tension, inability to sleep, inability to concentrate/ focus and irritability.
Attention Deficit/ Hyperactivity	Stimulants	• Amphetamine (Adderall) • Lisdexamfetamine (Vyvanse) • Dextroamphetamine (Adderal) • Pemoline (Cylert) • Dextroamphetamine (Dexedrine) • Methylphenidate (Ritalin and Concerta) • Dexmethylphenidate (Focalin)	• Appetite disturbances • Weight loss • Agitation • Sleep disruptions • Insomnia • Rage • Disorganization • Compulsions • Obsessive thoughts • Forgetfulness • Nervous movements • Suicidal ideation	Symptoms such as inability to focus, severe distractibility, inability to sit, fidgeting, irritability, impulsivity, excessive daydreaming, difficulty following directions/ listening, blurting out statements or words, and aggression.
	Non-Stimulants	• Guanfacine (Intuniv) • Atomoxetine HCL (Strattera)	• Irritability • Sexual dysfunction • Suicidal ideation • Blood pressure issues	
Anti-panic		• Clonazepam (Klonopin) • Paroxetine (Paxil) • Alprazolam (Xanax) • Sertraline (Zoloft)	• Drowsiness • Lack of coordination • Suicidal ideation • Agitation • Disruption of feeling intensity	Panic attacks with symptoms such as sudden fear, impending doom, or nervousness, physical symptoms such as sweating, rapid heartbeat, increased breathing, chest pains, and feeling as if one is dying. Symptoms are present without any actual threat present.

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Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Anti-obsessive		• Clomipramine (anafranil) • Fluvoxamine (Luvox) • Paroxetine (Paxil) • Fluoxetine (Prozac) • Sertraline (Zoloft)	• Agitation • Drowsiness • Sleep disruption • Appetite disturbances • Headache • Nervousness • Feeling emotionless • Suicidal ideation • Stomach upset • Fatigue • Sexual dysfunction	Obsessive thoughts that are repetitive and unwanted (they can come in words or pictures and can be violent, sexual, or scary); extreme fear of something such as germs, dirt, or contamination; fears that doors are not locked or the oven was left on; impulsive thoughts of hurting someone or shouting bad things at people; or a fixation on a negative thought or event.
Mood Stabilizers		• Valproic acid (Depakene) • Depakote • Eskalith • Lithium (Lithobid) • Lithonate • Lithotabs • Lamotrigine (Lamictal) • Gabapentin (Neurontin) • Carbamazepine (Tegretol) • Topiramate (Topamax)	• Weight gain • Tremors • Nausea • Appetite disturbances • Blurred vision • Dry mouth • Hives • Giddiness • Elimination disturbances • Seizures • Ringing in the ears	Illnesses such as bipolar disorder for symptoms such as rapid mood shifts, periods of euphoria and periods of depression, paranoia, excessive sleep periods, excessive wake periods, and impulsivity.
Sleep Medications		• Zolpidem (Ambien) • Amobarbital (Amytal) • Lorazepam (Ativan) • Diphenhydramine (Benadryl) • Chloral Hydrate • Triazolam (Halcion) • Eszopiclone (Lunesta) • Phenobarbital • Estazolam (prosom) • Temazepam (Restoril) • Alprazolam (Xanax)	• Sleepiness • Sleep walking • Dry mouth • Lack of coordination • Hallucinations	Inability to sleep, insomnia, frequent night awakening, repetitive nightmares.
Alpha Agonists		• Guanfacine (Tenex or Intuniv) • Catapres (Clonidine)	• Constipation • Dizziness • Drowsiness • Dry mouth	Used in attention/ hyperactivity disorders, to reduce anxiety, and to help regulate emotions.
Hormonal Agents		• Drospirenone and ethinyl estradiol (Yaz and Beyaz)	• Blood clots (especially when smoking) • Water retention • Irritability	Premenstrual dysphoric disorder including severe mood dysregulation.

Source: Adapted from National Alliance on Mental Illness. *Commonly Prescribed Psychotropic Medications*, available at www.nami.org.

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Source: Solchany, "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges" (Oct. 2011) *Practice & Policy Brief* (ABA Center on Children and the Law), pp. 9–11.

Appendix VI: Recommended Findings and Orders

- At every hearing, the court must find that the case plan meets the requirements of Welfare and Institutions Code section 16501.1. If it does not, the court must order the agency to comply. (Cal. Rules of Court, rules 5.690(c)(2)(B), 5.708(e)(2).)

- At every dispositional and detention hearing, and at all subsequent hearings that may affect a youth's receipt of education or developmental services, the court must consider and determine whether the youth's mental health needs, including any need for special education and related services, are being met. (Cal. Rules of Court, rule 5.651(b)(2).)

- At every hearing, the court must "ensure" the agency provided the information required by rule 5.651. (Cal. Rules of Court, rule 5.651(c).)

- At disposition, the court may require the production of other relevant evidence on its own motion. (Cal. Rules of Court, rule 5.690(b).)

- Findings and orders must address whether needs are being met, and what services, assessments, or evaluations the youth may need. (Cal. Rules of Court, rule 5.651(b)(2).) If the court determines a child is in need of mental health assessments, evaluations or services, the court "must direct an appropriate person to take necessary steps to request those assessments, evaluations or services." (Cal. Rules of Court, rule 5.649(d).)

- The court may, at any time after a petition has been filed, join in the proceedings any agency that the court has determined is failing to meet a legal obligation to the youth. If/when other responsible agencies are actually joined in the litigation, the court may request agency representatives meet before the hearing to coordinate provision of services. The court has no authority to order services unless it has been determined through the administrative process of the agency, that the youth is eligible for those services. (Welf. & Inst. Code, §§ 362, 727; Cal. Rules of Court, rule 5.575.)

- If court finds that youth needs a Regional Center or special education screen, the court may direct the rights holder to take appropriate steps. (Cal. Rules of Court, rule 5.651(b)(2)(C).)

- The court may make an order limiting a parent's right to make health and educational decisions for a youth, and must clearly and specifically set forth those limitations. (Welf. & Inst. Code, §§ 361(a), 362, 726, 727; Cal. Rules of Court, rule 5.695(b).) The court must identify the educational rights holder at each hearing. (Cal. Rules of Court, rule 5.649.)